PE385K

PENNSYLVANIA MEDICINE

January 1974

PHASE IV • PHASE IV • PHASE IV

'. . . the new proposals are enough to make most doctors and their advisors throw their hands up in despair. New formulas are proposed to "simplify" calculation of permitted fee increases, but they are presented in algebraic fashion sufficient to alarm us. Furthermore, the council issued a series of "Questions and Answers" to describe the newly proposed regulations, but which instead seem ory on several points. Still w gain required to post a sig chedule is on hand— at e in this requirem onths. . . Heaven help us!'

See Leif Beck's Interpretation—page 17

PSRO area designations announced - medigram - page 1
Society refused blanket exemption for medicaid fee increase - page 12
Fulfill Phase IV sign requirement - page 20

PENNSYLVANIA MEDICINE

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JANUARY 1974 VOLUME 77, NUMBER 1

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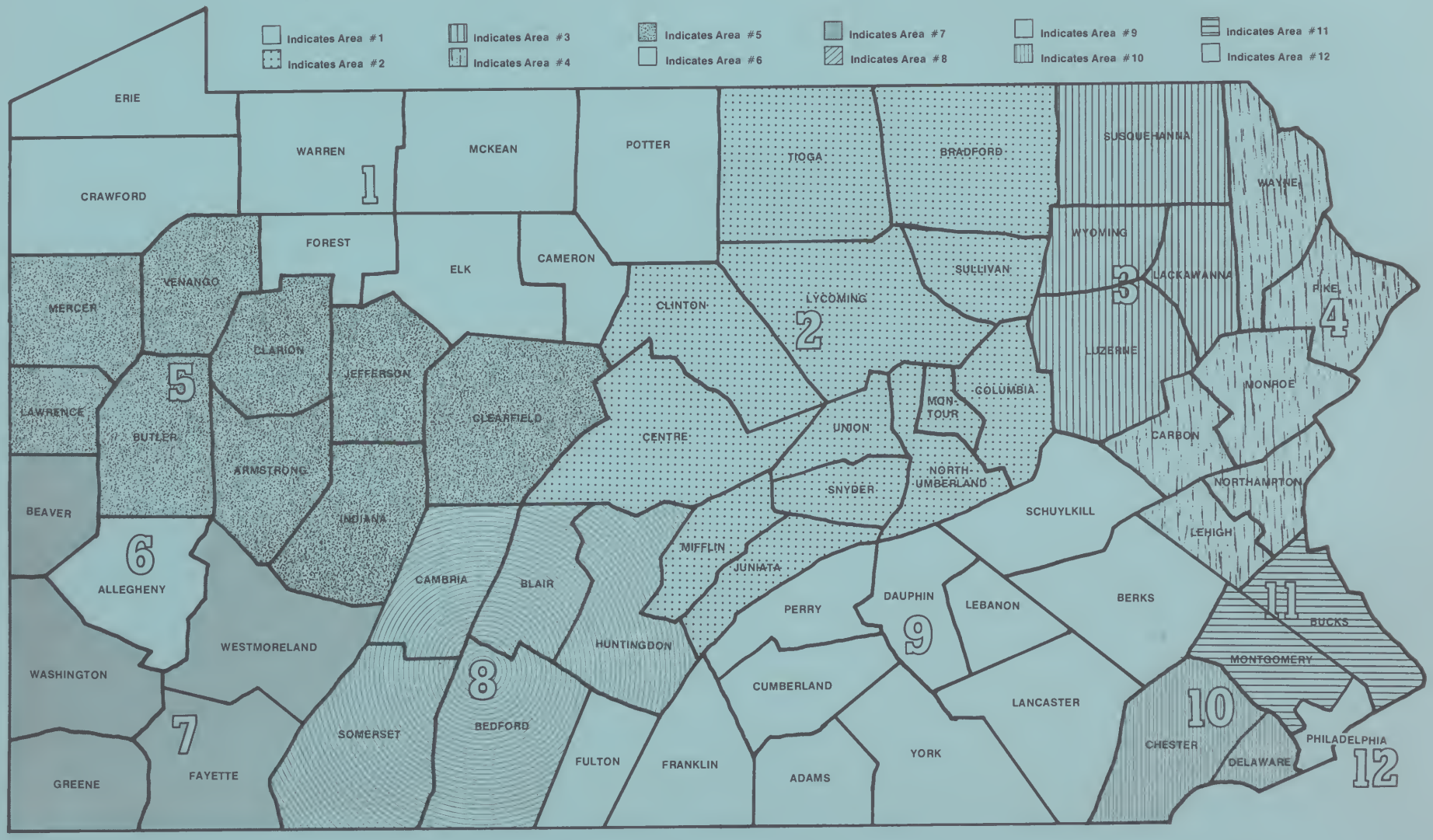
PENNSYLVANIA MEDICINE medigram January 1974

PSRO AREAS NAMED Professional Standards Review Organization (PSRO) geographic area designations were published December 19 in The Federal Register by the Department of Health, Education and Welfare (HEW). Matthew Marshall, M.D., president of the Pennsylvania Medical Care Foundation, said, "We are pleased to note that the twelve PSRO areas for Pennsylvania are identical to those suggested by the Foundation at the September 28, 1973 HEW meeting in Camp Hill. The Foundation's suggested boundaries were determined after considerable correspondence, meetings, and individual discussions with county medical society representatives across the state." The area designations are scheduled to become effective January 20, 1974 but HEW will accept comments until January 19, 1974. State Society officials took note of the role of the Foundation and its initiative in preparing for submission area designations based on recommendations from county medical societies. Dr. Marshall said questions or comments about the areas should be addressed to William A. McDaniel, Jr., Pennsylvania Medical Care Foundation, 20 Erford Road, Lemoyne, Pa., 17043. Information packets on PSRO contract applications will be in the mail shortly, according to HEW officials, but it is not yet certain to whom these will be sent; but Foundation officials believe all parties who received notices of the September HEW meeting will receive the packets. Contract applications will follow in early spring. HEW created nationwide 182 PSRO areas, 25 of which are statewide areas. It is expected that 50 contracts will be signed by June, 1974; 125 by January 1, 1975. By June 1, 1976, HEW expects all contracts to be signed. A map showing Pennsylvania area designations appears on the second page of this medigram.

FOUNDATION BOARD ELECTS OFFICERS The Foundation Board of Directors reelected the following officers for 1974: Matthew Marshall, Jr., M.D., president; Henry H. Fetterman, M.D., vice president; and Vincent Lechner, secretary. John F. Rineman, State Society executive vice president, was elected Foundation treasurer, and Larry R. Fosselman was appointed executive director.

AMA TO FIGHT PRICE CONTROLS ON PHYSICIANS In line with action taken at its recent convention, the AMA will continue its strong opposition to discriminatory Phase IV controls on physicians' fees. The House of Delegates authorized the Board of Trustees to take "appropriate legal action when so advised by legal counsel." Meanwhile, the Phase IV regulations are scheduled to become effective January 1, 1974. Read the article beginning on page 17 for an explanation, and post the sign facing page 20 of this issue.

ADDITIONS MADE TO SCHEDULE II Amobarbitol, secobarbitol, and pentobarbitol (Nembutal, Seconal, Tuinal, Amytal) were added to Schedule II of Controlled Substances by the Drug Enforcement Administration in rules effective December 17, 1973. The products had been on Schedule III. These prescriptions can no longer be telephoned; no refills can be ordered.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WAYNE
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CAMERON
WYOMING
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LACKAWANNA
PIKE
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MERCER
VENANGO
CLINTON
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LYCOMING
SULLIVAN
LUZERNE
MONROE
CLARION
JEFFERSON
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LAWRENCE
BUTLER
CLEARFIELD
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PERRY
DAUPHIN
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LEBANON
BERKS
11
BUCKS
WESTMORELAND
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MONTGOMERY
WASHINGTON
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CUMBERLAND
LANCASTER
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Learn how on the next page!

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PENNSYLVANIA MEDICAL SOCIETY
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Newspaper accounts about the world of medicine confuse the public. "Health care crisis . . . physician shortage . . . fee gouging . . . substandard care for the poor" are headlines which attract the reader and often mislead him.

Because you're busy practicing medicine you can't take the time to discuss the issues with your patients . . .

But you can be a silent spokesman by making use of the attached poster in your waiting room and the postcard below to order pamphlets to amplify the message. Fill out the card and mail it today . . . display the poster in your waiting room . . . be a silent spokesman this month and in months to come in a public education program sponsored by *your* State Medical Society!

I would like to take advantage of the new socio-economic information aimed at patients by requesting a quantity of the bill stuffers which will be similar to the tear-out poster in "Pennsylvania Medicine."

I will need _____ copies.

NAME: _____

ADDRESS: _____

_____

(Please print or type above)

January

Will you always be able to get the medical care you need?

You may have heard that there is a "crisis" in U.S. medicine. That there aren't enough doctors. That we have fallen behind in the treatment of illness. That the quality of medical care in the United States is *diminishing*. What are the facts?

FACT: Life expectancy is growing. The rate of U.S. infant mortality has declined by 25% in the last 10 years. Life expectancy at birth has risen from 69.7 years in 1960 to 71.1 years in 1970.

FACT: The number of doctors is growing. In the last 6 years, the number of medical students in the U.S. has increased by 33%. Of the 114 medical schools in the U.S., 24 were opened within the past 6 years. And more new schools are planned.

FACT: Our ability to fight disease is growing. Recent advances in medical science have controlled many of the old contagious killers like polio, diphtheria and whooping cough. And today, people are sicker for fewer days than they used to be, in part because almost everyone can now pay for good care when he needs it: Health Insurance Council figures show 92% of all Americans under 65 were covered by private hospital insurance in 1970.

FACT: We still have problems. A lot of them. One of the most persistent is the lack of adequate medical service in some areas because of the uneven distribution of physicians. The Pennsylvania Medical Society is working to solve this problem. For years we've operated a free placement service that helped communities to obtain physicians.

Another program provides loans to needy students, forgiving the loans if they practice in areas that need doctors. Two other programs interest students in medical care in communities away from the medical school complex. All of these programs help, but there's much yet to be done.

Your doctor is working with the Pennsylvania Medical Society to give you the finest medical care available anywhere. He can do this best if the people evaluating doctors are doctors.

The Pennsylvania Medical Society

Your doctor at work for everyone.

this is a sample of the pamphlet offered to accompany the sign published in the November 1973 issue—the exact size is shown—some are still available, as are some to accompany the December poster. . .

How do you know your doctor is a good doctor?

...is. Particularly when you ... can you be sure that your doctor can give it?

Most people can't be sure. They don't know if the medicine is correct or if the operation is really necessary. They must trust their doctor to know.

And your doctor does know. He keeps up with the latest techniques through continuing medical education programs. The Pennsylvania Medical Society requires its members to have 150 hours of formal continuing education work every three years.

Other doctors check your doctor. The Pennsylvania Medical Society maintains a pool of medical experts to review the work of individual doctors. Special committees investigate patients' complaints. You probably don't know that even in the hospital his work is being checked by other doctors. Medical review committees examine operations and the length of hospital stays. These committees are themselves systematically inspected and evaluated by teams of outside doctors.

What to do if you have a question. Ask your doctor first. Most questions and complaints can be resolved in the doctor's office—after all he knows you best. But if you feel you need further help, call your County Medical Society. They know your doctor and his record and can help to resolve complaints and misunderstandings.

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★ State Society "peer review" of individual claim or suit settlement disputes...

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★ Physicians previously insured under Lloyds' "claims made" policy have the option of purchasing retroactive "drop-back" coverage ...

★ Extensive involvement by State Society in underwriting, claims, classification statistics and rate-making developments...

★ Planned program of continuing education in malpractice claims avoidance and prevention...

Plan now on participating... with the State Society acting as the physician's "Ombudsman," it's like having your own insurance company... only better!

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1616 Walnut Street, Philadelphia, Pa. 19103
Attention: A. John Smither, Vice-President

☐ I am interested in participating in the PMS Liability Insurance Program. Please send me an application.

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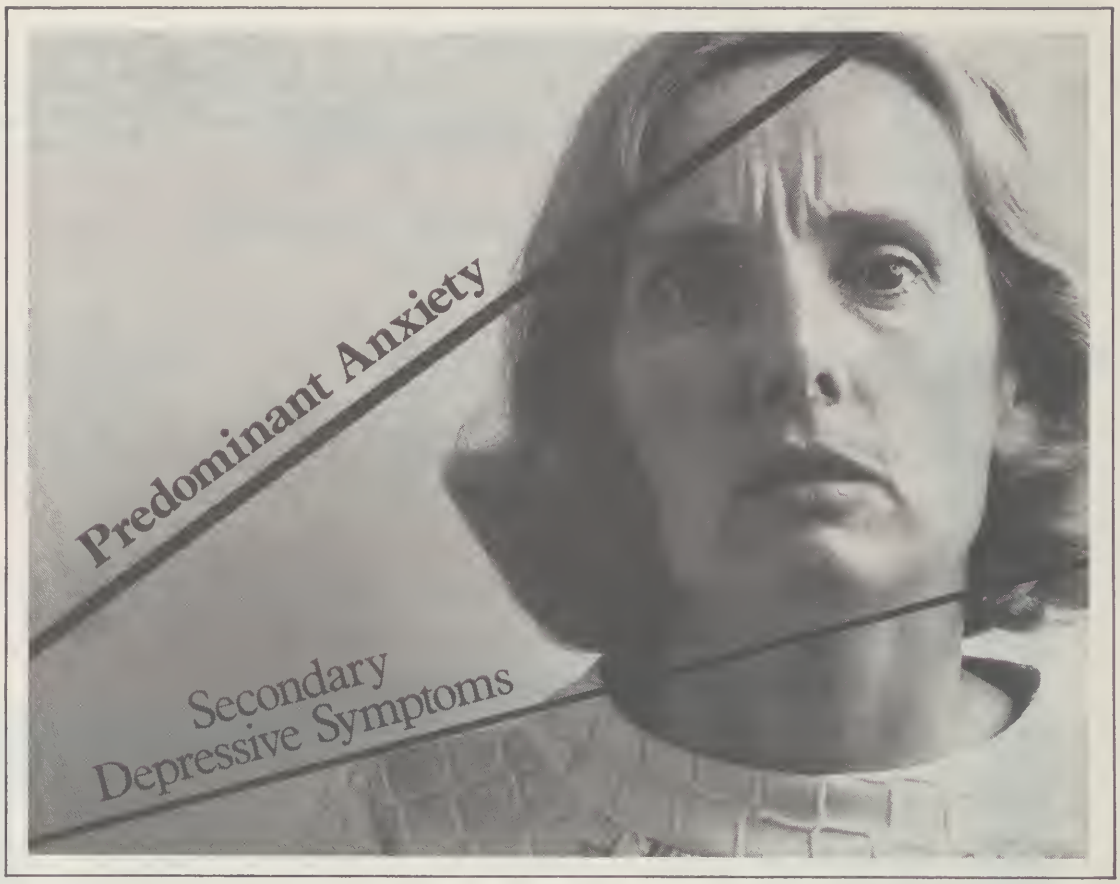

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Valium® 2-mg, 5-mg, 10-mg tablets
(diazepam)

Android®-25 Tablets

Android-10 Tablets **Android-5** Buccal

Methyltestosterone N.F. – 25, 10, 5 mg.

For the treatment of impotence due to androgenic deficiency in the male.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In **the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057 REFER TO PDR

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The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol C III SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics. **Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin®

2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) — For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn

MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

COLC refuses blanket exemption on medicaid fees

The Cost of Living Council (COLC) has turned down the Society's request for a blanket exemption so that physicians treating patients under medicaid might receive the long fought for increase in fees granted early in 1973 by the Department of Public Welfare.

The Society is pursuing the matter further, and progress will be reported to members as soon as possible. The refusal letter, over the signature of John D. Twiname, administrator of the Office of Health of COLC, expressed sympathy, but said each physician would have to go it alone in requesting an exemption to increase fees for medicaid patients from $4.00 to $6.00 for office visits and from $5.00 to $7.00 for house calls. The texts of the letter to Twiname from John F. Rineman, executive vice-president of the State Society, and Twiname's reply appear below and on the facing page in full.

Without an exemption, physicians might be able to increase these fees by $1.00 under the new Phase IV rules which apply to physicians, beginning January 1, 1974. An article beginning on page 17 of this issue explains the new Phase IV rules for physicians.

Society officials have been working for years to bring about an increase in fees paid for medicaid patients. The granting of the increase finally came, but after fees were frozen and increases limited when the economic stabilization program was put into effect.

The Commonwealth joined the State Society in the request for a blanket exemption so that physicians treating medicaid patients might take advantage of the increase, which still would leave Pennsylvania physicians far behind those in a number of other states who receive even higher fees for this service to the needy.

Philadelphia CMS installs Dr. Templeton

The newly installed president of the Philadelphia County Medical Society is John Y. Templeton III, M.D., Rosemont.

Dr. Templeton is a consultant in thoracic surgery at Chestnut Hill Hospital and Wilmington Medical Center, a consultant in cardiac surgery at Haverford Hospital, a consultant in general surgery at Lankenau Hospital, attending surgeon at Thomas Jefferson University Hospital and at Our Lady of Lourdes Hospital. He is Samuel D. Gross professor of Surgery and head of the department of surgery at Jefferson Medical College of Thomas Jefferson University.

Dr. Templeton, a graduate of Jefferson, is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He has served on the council and as vice president of the Philadelphia Academy of Surgery and as president of the Laennec Society of Philadelphia and of the John H. Gibbon Jr. Surgical Society.

He is a fellow of the American Surgical Association, the American College of Surgeons, and the American College of Chest Physicians. He also holds membership in the International Society of Surgery, the International Cardiovascular Society, and is a member of the professional education committee of the Heart Association of Southeastern Pennsylvania.

November 7, 1973

Mr. John D. Twiname
Administrator
Office of Health, Room 5302
2000 M Street, N.W.
Washington, D.C. 20508

Dear Mr. Twiname:

In January of this year, the Pennsylvania Department of Public Welfare determined to increase the maximum payment made under the Medical Assistance Program for physicians' office visits from $4 to $6 and for home visits by a physician from $5 to $7. Further, it was determined that approximately eighty emergency room procedures which heretofore were not authorized for payment would now be reimbursable. The Pennsylvania Medical Society recognized that the Phase III regulations which were in effect at that time would nullify the effect of this new policy for many noninstitutional providers unless they sought individual exemptions through the Cost of Living Council.

It is our understanding that the Pennsylvania Department of Public Welfare sought and obtained authorization from the appropriate federal agency to increase payments under the Medical Assistance Program, and it was our belief that the same logic which prevailed then could be used to seek a blanket exemption for all participating Pennsylvania physicians. With this in mind, the Society made a formal request to the Pennsylvania Health Care Advisory Board for a blanket exemption for physicians whose participation in the Medical Assistance Program would result in an increase in their aggregate income beyond the stipulated 2.5 percent under the then current Phase III regulations. In addressing our request, we indicated that the new fee limits established by the Pennsylvania Department of Public Welfare were designed in part to redress a long-standing payment inequity. Traditionally, other providers, i.e., pharmacists and hospitals, have received more equitable reimbursement for services and products than have physicians. To the extent that the Department of Public Welfare has grievously discounted physicians' services, we believe that these new fees represent limited catching up to the marketplace which is long overdue. Further, we believe the new fee limits are designed to help increase the availability of medical care to DPW clients by making the physician fee schedule more realistic. The old office fee of $4 was so low as to not even cover a physician's overhead in many parts of the state.

It was not until October 12, 1973, that the Society received an official reply to our request. Enclosed is a copy of the letter from the Pennsylvania State Advisory Board which recommends to the Cost of Living Council that the requested exemption be granted.

AMA acts on four

Society authorized to give Category One credit

The Pennsylvania Medical Society was accredited in November to present programs of continuing medical education that may be reported in Category One for the Physician's Recognition Award of the American Medical Association and for the PMS membership requirement.

Three other Pennsylvania-based institutions were also accredited. They are: Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center, Hershey; American Society for Adolescent Psychiatry, Wallingford; and the Regional Council of Child Psychiatry, Wallingford.

All Pennsylvania medical schools have now received AMA Category One accreditation.

Urology course on loan

A videotape system of medical teaching is currently being used by the division of urology at the Milton S. Hershey Medical Center of Pennsylvania State University.

The system was presented to Thomas Rohner, M.D., and to Nicholas M. Nelson, M.D.

Physicians interested in using the films at Hershey or in their own communities can obtain them by contacting the division of urology at the medical center. Telephone: (717) 534-8848.

MCP announces Dr. Slater to be new president

The Medical College of Pennsylvania (MCP) has selected a new president who will assume his office in May 1974. He is Robert J. Slater, M.D., president of the Foundation for Child Development in New York City.

DR. SLATER

He has served as dean of the University of Vermont College of Medicine, has worked with the Research Institute of the Hospital for Sick Children in Toronto, Canada, and was an associate in the department of pediatrics at the University of Toronto.

The announcement of the new president came from the chairman of the board of MCP. Dr. Slater will succeed Bernard Sigel, M.D., present dean and acting president.

Maternal-fetal ICU opens

A maternal-fetal intensive care unit for high-risk pregnant patients and their babies which will open in January 1974 at Magee-Womens Hospital has been allocated a $500,000 grant by the University Health Center of Pittsburgh, funded by the Richard King Mellon Foundation.

The unit will be available to all Allegheny County obstetricians.

We, therefore, respectfully request that you approve a blanket exemption for Pennsylvania physicians for increased payments under the Medical Assistance Program in view of its cost justification.

We are most anxious to hear from you in this regard.

John F. Rineman
Executive Vice President
Pennsylvania Medical Society

December 5, 1973

Mr. John F. Rineman
Executive Vice President
Pennsylvania Medical Society

Dear Mr. Rineman:

Thank you for your letter of November 7 in which you outlined the state of physician reimbursement under the Medical Assistance Program in Pennsylvania. My experience has taught me that reimbursement levels under public programs may not adequately reflect the costs of providing services. I am, therefore, pleased that the Pennsylvania Medical Society and Department of Public Welfare are active in this area.

Although the Department of Public Welfare received authorization to offer physicians a higher maximum reimbursement, it is still the responsibility of the individual physician to determine whether or not he can accept higher payments under the Economic Stabilization Program regulations. These regulations have prohibited price increases greater than 2.5 percent unless the physician has received an exception. They were designed to reduce inflation in medical care prices to an acceptable level. It seems to me that the situation you present is an example of the salutary effects of the program since physicians may have to selectively implement the limited price increases.

Although we cannot grant a class exception, recourse to the exceptions process is always available to any physician. The newly proposed Phase IV health regulations provide for the granting of exceptions to medical practitioners to prevent or correct a serious hardship or gross inequity. One of the criteria used to determine hardship is: (Sec. 150.513 [a]) ". . . prices . . . or revenue margin are not substantially representative of the petitioner's current practice."

I hope that where a hardship exists the physician will apply for an exception and that you will assist him in preparing the application and in explaining the circumstances.

I appreciate your interest and urge your continued cooperation with the Economic Stabilization Program.

John D. Twiname
Administrator
Office of Health

Pennsylvania Blue Shield medicare procedure

I. R. PERKIN
Camp Hill

Mr. Perkin is director of medicare operations for Pennsylvania Blue Shield.

In 1973, Pennsylvania Blue Shield (PBS) serviced a population of 1.3 million medicare beneficiaries and paid out an estimated $120 million in medicare benefits. In doing so it handled over 12,000 claims per working day. An awareness on the doctor's part of *how* PBS screens and reviews these claims for payment can help assure that both doctor and patient receive prompt and accurate reimbursement for eligible services.

Questions are sometimes raised by the medical community about professional fees which are reduced or disallowed. Understandably, doctors are upset when their bills are not paid as submitted. And doctors are frequently unhappy with the explanations they receive as to why their fees are questioned at all. Why are reductions made? How does the system work?

A brief review of the basic medicare law and associated regulations can explain some of the mystery. Further, an understanding of PBS's medical review system can help dispel some misunderstandings and misconceptions. It can also shed some light on what doctors can do to expedite processing of their medicare claims by PBS.

As a medicare "carrier", PBS is engaged under contract by the Secretary of Health, Education, and Welfare. Administration of the contract is supervised by the Social Security Administration (Bureau of Health Insurance, to be exact). The terms of the contract require PBS to perform certain specific tasks. These include the responsibility (a) to pay claims on a "reasonable charge" basis and (b) to assure that all services are "medically necessary."

An understanding of these responsibilities and the tasks associated with them, the constraints they impose, and their attendant impact on claims handling is fundamental to an understanding of *how* PBS pays medicare claims.

This is the first of two articles dealing with how Pennsylvania Blue Shield reviews medicare claims. The next will treat eligible medicare services.

Pennsylvania Blue Shield in its medicare operation serviced 1.3 million beneficiaries, paid out an estimated $120 million dollars, and in so doing handled every day over 12,000 claims, many with as high as thirty services listed. Over seventy physicians, representing twenty-eight specialties, do reviews. In case you think a clerk or computer handles reviews, or in case you'd like to know how such an operation functions, read this article!

Determining Reasonable Charge

The *reasonable charge* for a specific service is the lowest of the following: (1) the doctor's customary charge of record, (2) the prevailing charge in the same locality for the same service, and (3) the actual charge submitted by the doctor on a claim, statement or bill. Customary charge profiles and prevailing charge data are developed, maintained, and periodically updated subject to Social Security Administration and Cost of Living Council restrictions. Claims are compared to these records or profiles and priced on the basis of the lowest of the three charges. Payment is then made based on the reasonable charge as defined above.

This process is frequently tempered, however, by the second contractual mandate that PBS must also determine medical necessity. In effect, PBS must assure, insofar as possible, that the reported services were reasonable and necessary for the diagnosis and/or treatment of the beneficiary's illness or injury. Generally, three types of checks are made to do this. These checks involve criteria designed to match diagnoses with reported services, frequency of service, and level of care.

Determining Medical Necessity

It is here that the medical review system takes over. A number of checks or screens are used in the computer processing system to intercept claims exceeding certain criteria. The criteria upon which these screens are built come from various sources. Some were imposed by the Social Security Administration. Others have been recommended by the Pennsylvania Medical Society, Pennsylvania Osteopathic Medical Association, Pennsylvania Podiatry Association, specialty groups, professional societies, and other Blue Shield Carriers.

In general, these criteria apply to claims which fall into three broad categories: those which exceed certain dollar amounts, those which involve a specified number of occurrences, and those which involve concurrent care.

Once a claim is intercepted by any of these screens, it enters the medical

explained, review mechanism outlined

review system. It is, in effect, set aside for review by specially trained examiners. Following physician-approved guidelines, these examiners study the claim for circumstances which could warrant payment beyond the norm. In other words, they determine medical necessity both from the information on the claim and on the basis of guidelines from the same sources which helped to develop the basic screens. Occasionally when key information is missing, they will "develop" the claim by requesting additional data from the doctor; generally, however, payment is based upon information furnished on the claim form.

The examiners cannot *deny* payment without specific guidelines. If clear-cut written instructions (approved by physicians) are not available, the claim is referred to a medical director (a practicing physician) or to a medical advisor when more precise specialty knowledge is required. PBS's medical advisory system, administered by a physician who is vice president for medical affairs, involves over seventy physicians encompassing some twenty-eight specialties and is designed to provide expert technical advice.

The claim is then paid based upon recommendations made at the appropriate level of review. Few claims, however, travel this entire review route prior to final determination. Most are paid at the initial review and in consonance with the terminology and procedures contained in PBS's Procedure Terminology and Manual.

When You Are Dissatisfied

When a doctor questions payment or requests a special review of his claim, a separate and independent re-examination of the case is made. Frequently, additional information furnished with the request for review readily justifies the medical necessity for an added charge or service which was not apparent during initial processing. Pertinent information such as hospital records, operative notes, anesthesia notes, x-rays records, and pathology reports may also be required in order to assure equitable judgment.

Here again, claims reviewers may not uphold an original denial without specific written guidelines. Unless these exist, the claim must be referred to the medical director or medical advisor level for professional review. Should an advisor or director deem it necessary or appropriate, he may also elect to refer a claim for peer review. This review is accomplished by the Pennsylvania Medical Society's specialty review committees, the Pennsylvania Osteopathic Medical Association, or the Pennsylvania Podiatry Association.

Finally, in the event a doctor is still dissatisfied with his payment; the law provides for a medicare fair hearing if the amount in controversy is $100 or more (either a single claim or total of several claims). During the hearing, conducted by an impartial hearing officer, the doctor or his representative may offer evidence in person or by mail. He may present his own witnesses or examine the carrier's. Medicare law does not provide for any further appeal or for judicial review by state or federal courts.

Thus, a claim may receive as many as three reviews. The vast majority pass through the initial computer-examiner review and are generally paid within ten days to two weeks. A special request for review may take longer when pertinent records are needed and an attendant delay is encountered in obtaining them. The fair hearing review requires advance scheduling and takes the longest time to accomplish (only a very small percentage of claims ever find their way to a fair hearing).

PBS claims personnel are sincerely motivated to pay claims promptly and correctly. However, they are frequently frustrated because of missing information, illegible writing, and incomplete reporting. The best way to insure rapid, accurate processing and payment of a claim is to submit it in typewritten form and in accordance with the procedures outlined in PBS's Procedure Terminology and Manual. Further, should there be any doubt on any aspect of claim submission, a PBS Professional Relations Representative will call and provide first-hand guidance. These representatives are headquartered in district offices located in Philadelphia, Pittsburgh, and Camp Hill; and any doctor can avail himself of their services by either calling his representative directly or by calling the nearest district office for assistance.

Assistants schedule March seminar

Physicians have found it helpful in improving the professionalism and job performance of their medical assistants, secretaries, nurses, technicians, and receptionists to send them to educational seminars of the Pennsylvania Society of the American Association of Medical Assistants (AAMA).

A weekend seminar will be held on Saturday and Sunday, March 30 and 31, 1974, at the Penn Harris Motor Inn in Camp Hill (just outside of Harrisburg). Registration will open at noon with the program beginning at 2 p.m. on Saturday and will continue until 12:30 p.m. Sunday.

Meetings will cover bookkeeping and insurance for the medical office, administrative procedures, patient management, and medical law and legislation for the medical assistant. The guidance provided by these meetings is designed to help update office procedure and improve efficiency.

The fee for AAMA members is $15 and for others $20, which includes the Saturday night banquet. Registration forms may be obtained from Mrs. Jane Ireland, 4032 Watters Lane, Gibsonia, Pennsylvania 15044.

Herpes warning issued

A newly identified venereal infection caused by several strains of the common herpes viruses is spreading rapidly, J. Finton Speller, M.D., Pennsylvania secretary of health announced recently.

Dr. Speller hopes to assign health department staff to set up a diagnostic service which will be available to physicians because of potentially serious complications that can result from the newly identified disease.

Certain pharmacy board rules affect physicians

Since the May 1972 article in PENNSYLVANIA MEDICINE which carried on page 17 an explanation of the new Controlled Drug, Device, and Cosmetic Act, PENNSYLVANIA MEDICINE has carried several articles of interest to physicians as new rules and regulations implementing the law were issued. The following article is a comprehensive report of the regulations adopted by the State Board of Pharmacy as they pertain to physicians.

After more than forty-five months of study, meetings, drafting, publication, hearings, revision, and republication, pharmacists in the state have a new set of rules and regulations. In addition to spelling out the physical requirements of pharmacies, the rules determine the format of prescriptions and thus impact on physicians.

New Rules on Labeling

Under the new rules, the container in which a prescription drug or device is sold or dispensed must bear a label with all of the following:

(1) Name, address, telephone number of the pharmacy and the BNDD number assigned to it by that bureau;

(2) The name of the patient;

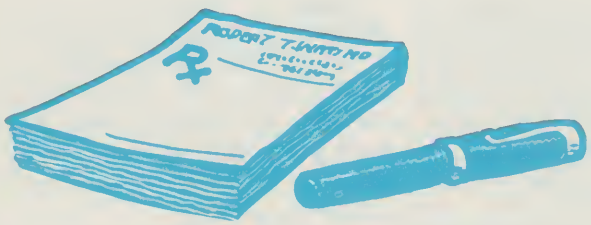
(3) Full directions for the use of its contents;

(4) The name of the prescriber and any registration number of the prescriber required to be obtained pursuant to applicable federal law;

(5) Serial number of the prescription and the date originally filled;

(6) **The trade or brand name of the drug and proportion or amount of drug dispensed, unless omission is specifically requested by the prescribing doctor in writing. If the name is generic, then the manufacturer's name shall also be shown.**

(7) On all controlled substances, the statement: "Caution: federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."



Schedule II—Prescriptions

Prescriptions for Schedule II controlled substances must be written with ink or indelible pencil or typewriter and MUST BE MANUALLY SIGNED BY THE PRESCRIBER.

Schedule II, III, and IV Rules Set

(1) Prescriptions for Schedule II controlled substances may not be refilled.

(2) No controlled substance in Schedule III or IV may be filled or refilled more than six months after the date of the prescription or be refilled more than five times, unless renewed by the physician.

Physician Must Set Number of Refills

All other caution legend drugs which may be renewed for a longer period of time or for a greater number of refills must be in specific numbers, such as "may be renewed ten times" and must be in the original handwriting of the prescriber.

No caution legend drug which is refillable by law shall be refilled on the basis of preprinted designations or "ad lib," P.R.N., or similar instructions more than six months after the date of the prescription or more than five times.

Schedule V—Cough Preparations Regulated

No pharmacist or pharmacy may dispense, dispose of, or sell any Schedule V cough preparation containing codeine, dilaudid, or any other narcotic cough preparation without a prescription, except that this provision shall not apply to such preparations used within an institution.

Prescription Needed for Needles and Syringes

Sales of needles and syringes shall be made by a pharmacist only to persons showing a prescription issued by a physician. The prescription shall be in force for a maximum of one year from the date of its issuance. This clause went into effect September 2, 1973.

When Prescriptions Lapse

No prescription may be knowingly filled or refilled which was written for prior use by a physician who is no longer in practice or deceased.

Telephoned Prescriptions

A prescription by an oral order (telephone or otherwise) may be received and transcribed ONLY by a registered pharmacist.

Pick-Up, Delivery Regulated

A pharmacist may not enter into an arrangement with a nonlicensed person whereby prescriptions or prescription drugs and devices are regularly left with, picked up from, solicited by, accepted by, or delivered to such a nonlicensed person.

At the same time, there is no prohibition against a licensee from picking up a prescription or delivering a prescription drug or device, at the request of a patient, at the office or home of the prescriber or patient, at an institution in which the patient is confined, at such other place the

(Continued on page 31)

practice management

Phase IV fee rules—heaven help us!

LEIF C. BECK, LL. B.
Bala Cynwyd

Mr. Beck is President of Management Consulting for Professionals, Inc. of Bala Cynwyd, Pennsylvania

On October 5, the Cost of Living Council proposed new regulations governing increases in medical fees under the federal price controls. These new rules would, if adopted as anticipated, become effective January 1, 1974. Since my recent article described in some detail the rules in effect since 1971, (see PENNSYLVANIA MEDICINE, November 1973, page 28) this writing is intended to follow up by discussing the proposed changes.

As a general matter, the new proposals are enough to make most doctors and their advisors throw their hands up in despair. New formulas are proposed to "simplify" calculation of permitted fee increases, but they are presented in algebraic fashion sufficient to alarm us. Furthermore, the council issued a series of "Questions and Answers" to describe the newly proposed regulations, but which instead seem absolutely contradictory on several points. Still worse, each practice is again required to post a sign stating that a price schedule is on hand—at least the fifth change in this requirement in twenty-seven months.

Nevertheless, the rules have the force of law and require adherence. therefore, this early description of the new rules will give readers an opportunity to plan their actions as to possible fee changes.

Effective Date of New Rules

If adopted as proposed, these new requirements would be effective January 1, 1974. Any fee increased on that date or thereafter would (except as noted below) have to satisfy them. Practices on other than a calendar year basis, however, continue subject to the *old* rules until their fiscal year ends in 1974, and presumably the new provisions would not apply to them until their new fiscal year begins. A professional corporation whose fiscal year ends on June 30, for example, would apparently not become subject to the proposed regulations until July 1, 1974.

Accumulation of Unused Increases

If a practice has not increased fees by the allowable 2.5 percent per year in each of 1972 and 1973, it may carry the unused portion over to 1974 or later. According to the questions and answers, such a "make-up" increase would be considered under the *old* rules. Therefore, a practice which has not raised its fees at all in 1972 or 1973 could nevertheless raise them on January 1, 1974, to the extent they satisfy *all three* of the following old requirements:

(1) The increase will not increase the practice's gross income by more than 5 percent (2.5 percent for each of 1972 and 1973);

(2) The increase will not cause the practice's profit margin to become greater than its base period profit margin; *and*

(3) The increase will not be greater than the increase in "allowable costs" (generally all practice expenses) since the last fee increase or January 1, 1971.

All three of these requirements were discussed and described in my prior article.

Any such "make-up" fee increase in 1974 is, however, made subject to one additional requirement. No individual fee for any service may be increased by more than 10 percent; if the fee was less than $10 before the change, then it may be increased by $1 even though that would be more than a 10 percent change. Thus a practice could not make its "make-up" increase for a $300 surgical procedure to more than $330 even if it meets all three of the old rules; nor could it raise its $8 office visit fee to more than $9.

The newly proposed fee increase rules will also be cumulative. Therefore, the basic new 4 percent limitation (discussed below) could be passed up in 1974 so that a practice could increase its fees subject to an 8 percent limitation in 1975, and so on.

The Three New Limitations Summarized

Much as under the old regulations, medical practices would have to satisfy *all* of three separate limitations for a proposed fee increase to be proper. Very briefly stated for convenience, the three new limits are:

(1) No individual fee may be increased by more than 10

PHASE IV

Be sure to clip your sign facing page 20 and post it in your waiting room!

percent, except that a fee of $10 or less may be increased by $1;

(2) No fee may be increased so it would result in an "aggregate weighted price increase" of more than 4 percent per year over that of the prior year; *and*

(3) No fee increase may increase a practice's "revenue margin" (measured *after* the increase) over the revenue margin for the "base period."

Each of these three new requirements are described in greater detail below.

The First New Limit
The 10 Percent or $1 Rule

Whereas the old rules have permitted a doctor to raise any individual fee as much as he considers appropriate, subject only to the effect on overall gross income and profits, there will on January 1, 1974, become a limit on how much any single fee can be changed. The fee for a service or procedure cannot be increased by more than 10 percent, except that it may in any such event be increased by $1. Thus, any fee of $10 or less (office visits, lab charges, etc.) could be increased only $1, while any higher fee could become only 10 percent higher.

Practices should note that this limit applies *even if* the proposed increase is for several years. For instance, a group which in 1974 defers increasing a fee it considers unusually "underpriced" could not wait until 1975 and increase it by 20 percent (or $2). The effect may be to pressure doctors to consider changing their low fees *each year* rather than to wait another year and make one change to the proper level.

The Cost of Living Council's stated reason for inserting this new 10 percent or $1 limit is to enable patients themselves to better monitor the legality of any fee changes. A patient, for example, who has been paying $8 for his visits to the doctor could presumably instantly recognize an illegal change if his visit in 1974 was billed at $10.

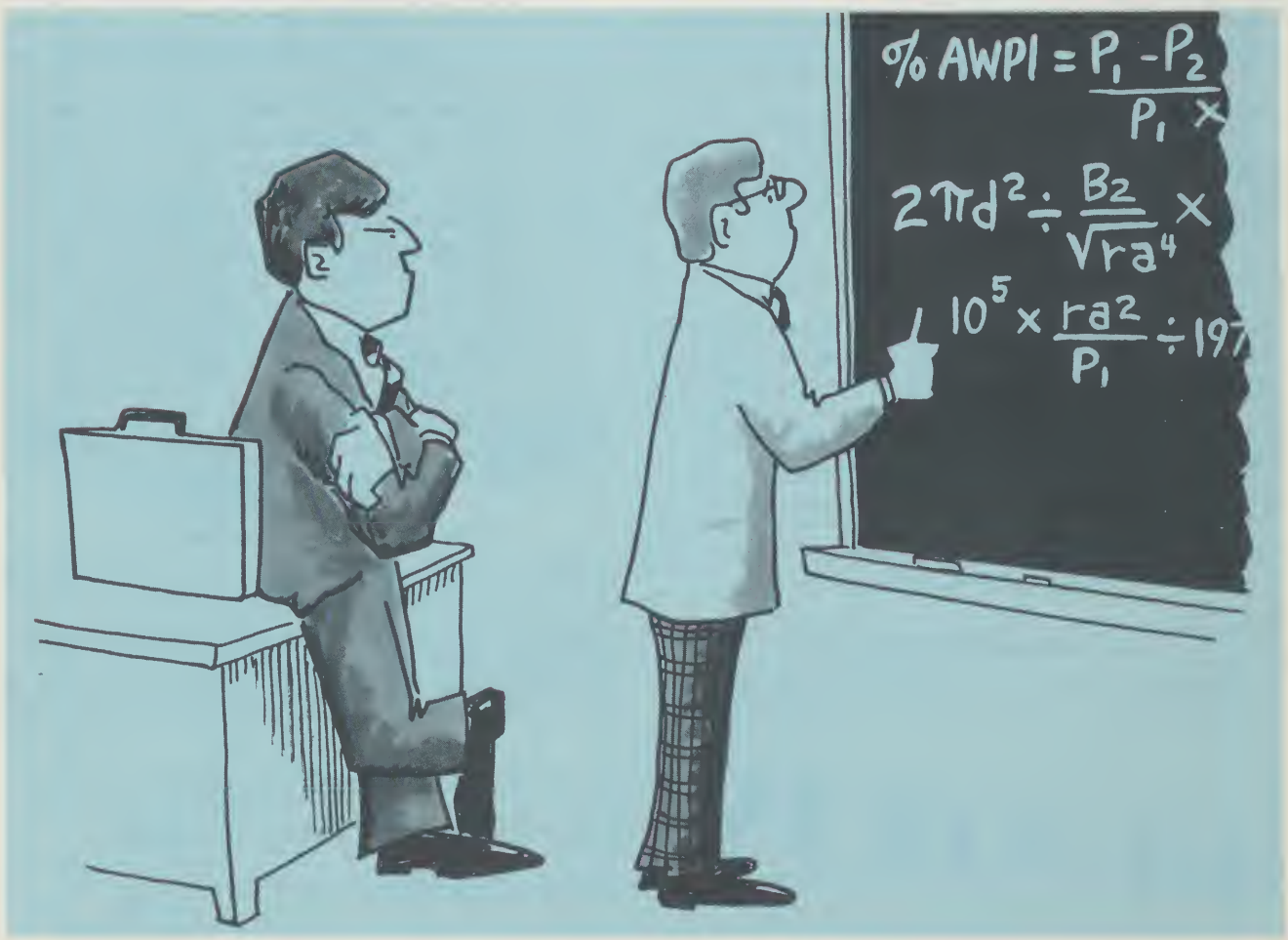
The Second New Limit
The 4 Percent Rule

Instead of the relatively simple 2.5 percent rule, the proposed regulations provide that the "aggregate weighted price" can not be increased by more than 4 percent per year because of a fee increase. This introduces brand new concepts and requires complicated record-keeping and mathematics. Perhaps to impress us with the rule's simplicity, the proposed regulations have reduced its calculation to a formula:

$$\%\,\text{AWPI} = \sum \frac{P_1 - P_2}{P_1} \times \frac{B_1}{B_2} \times 100$$

Heaven help us!

The gist of this rule is to lessen the amount a fee for a commonly provided service may be increased. I believe, for example, that it would be virtually impossible for a practice to raise a $10 fee (such as for an office visit) the otherwise



permitted $1 if that type fee produces 40 percent of the practice's income.

In the formula reproduced above, the $\frac{P_1 - P_2}{P_1}$ portion apparently refers to the percentage a specific fee is increased.* The $\frac{B_1}{B_2}$ portion refers to the percentage effect the fee being increased had on *total* billings in the *previous* complete calendar year. Multiplying these two factors and then multiplying the result by 100 would produce the "aggregate weighted price increase," which cannot for all fee increases in a year exceed in total 4 percent per year.

Perhaps two examples will help explain what I perceive to be the workings of this test:

(a) Dr. A (or Group A) wants to increase his fee for office visits from $10 to $11 on January 1, 1974. For calendar year 1973 (that being his fiscal year), there had been 5,000 office visits and total billings were $110,000. All fee increases under the old 2.5 percent per year rules had been adopted. The increase would *not* be permissible because the formula would show:

$$\frac{\$11 - \$10}{\$10} \times \frac{5{,}000 \times \$10}{\$110{,}000} \times 100 = 4.5 \text{ percent}$$

(b) Dr. B (or Group B) wants to increase his fee for normal deliveries from $300 to $325 on the first day of his corporation's next fiscal year, which will be February 1, 1974. For the fiscal year ending January 31, 1974, there were 200 such deliveries and the total practice billings were $132,000. All prior allowable increases had been taken. The increase *would* be permissible under the following calculation:

$$\frac{\$325 - \$300}{\$300} \times \frac{200 \times \$300}{\$132{,}000} \times 100 = 3.8 \text{ percent}$$

This proposed new rule has several important features. First, increasing a fee on the first day of a new year would be almost impossible unless the practice had immediate bookkeeping figures for the year just completed. And the practice would require accurate records as to the number of times each service is provided, which larger practices would normally have through computer billing and bookkeeping, but which smaller practices often lack. I urge clients, however, to develop these bookkeeping capabilities at least on a monthly basis, so the new rule tends merely to strengthen my argument.

Second, and happily, this 4 percent rule can be calculated with presumed accuracy since it is based on the prior year's records. The old 2.5 percent rule was based on projections of work patterns in the year following the fee increase, which involved real guesswork. Interestingly, my prior articles had suggested merely using the prior year's numbers as the most reliable indicator of future activity, which idea the new 4 percent rule seems to have adopted.

Third, the proposed regulations base the test on billings for services rather than on collections. This can be difficult for badly managed practices which fail either to adequately

record charges or to accumulate them into monthly and yearly totals. Once again, the pressures are increasing for small practices to improve their record-keeping and bookkeeping systems.

The Third New Limit
The Revenue Margin Rule

This proposed rule is essentially the same as the "profit margin limitation" under the old regulations—the practice's profit or revenue margin cannot become higher as a result of the fee increase. The proposed definition of "revenue margin" appears to be essentially unchanged from that of the old "profit margin," in either case it being a practice's net income after expenses divided by its total receipts.

The new rule, however, is in my view terribly objectionable in one important respect. It is not capable of calculation in advance of the fee increase, thus leaving a practice uncertain whether it will *actually* meet the test (and hence whether the fee increase really is proper) until at least a year has elapsed.

If a fee is increased during the first three months of a year (calendar or fiscal), then the practice's revenue margin for that *entire* year cannot be higher than for the "base period" (which continues to be any two years from 1968). If a fee is increased later in a year, the revenue margin for *both* that year and the following year cannot be higher than the average for the selected base period years, causing a delay of another year before one can be sure the fee increase was proper. There is no indication as to what penalties might occur if a fee increase projected in good faith to satisfy this test thereafter actually fails it.

I have urged the Cost of Living Council to drop this

**It appears to this author that the regulations have reversed the formula incorrectly, for I believe it should be* $\frac{P_2 - P_1}{P_1}$

forward-calculation feature in favor of a limitation capable of calculation when the fee change is being *considered*. A medical practice cannot and should not predetermine its level of activity, yet growth of a practice and/or its increased efficiency could, under the new rule, defeat a fee increase adopted over a year earlier. Perhaps worse, a doctor who later sees that his practice's activity has increased to the point that his fee change adopted in good faith is becoming illegal will virtually be forced to "take a vacation" or otherwise cut back on his production.

In my view, the rule should either (1) measure the revenue margin as of the most recently completed year with the effect of the fee increase added in, or else (2) estimate the revenue margin for the twelve months following the date of the fee change. If the rule is not changed, I will generally consider both of these alternatives as a means of advising whether a client should go ahead with a desired fee revision. And once the change has gone into effect, I will urge periodic follow-up calculations to see if actual activity is keeping the change legal.

Whereas the regulations define "revenue margin" in the usual accounting sense, tieing to gross *receipts*, the questions and answers give a practitioner the option to calculate on the basis of *billings*. Whichever is used must presumably be applied consistently, and the alternate use of billings (charges for services as they are performed even if not yet paid for) is appropriate only if consistent with the practice's accounting systems. In most cases, therefore, I would assume that only the usual idea of "net income"—moneys *collected* less moneys spent—would apply and that billings will not be a real alternative.

If a practice has incorporated during or since the "base period" the proposed regulations expressly call for subtracting from income "any salary or pension or other deferred compensation" in excess of what is allowed under a Keogh plan (usually $2,500 per year) for any doctors who are officers or stockholders. I had recommended the same procedure in making the old profit margin test meaningful, although the proposed regulation seems generous in ignoring certain other costs and benefits of professional corporations.

Fee Schedules and Signs

Here we go again! The proposed rules require having available a schedule of the practice's fees. And each practice must again dredge up and post its sign, which shall be "conspicuous and easily readable," stating that the fee schedule is available and where it may be obtained. The amount of governmental flip-flopping on this sign requirement, at least the fifth change since August 1971, seems Orwellian even to a veteran government-watcher. Nevertheless, medical practices will have to comply promptly with the following expanded rules.

Most practices now have a fee schedule available to meet the prior requirements. That schedule will undoubtedly have to be revised and amplified considerably. It will have to show the fees in effect on October 1, 1973 for all those items which together comprise 90 percent of total revenues. It will also have to specify each fee increase occurring after that date, when it occurred, and the "weight" of the service involved in calculating whether the fee change met the previously described 4 percent rule. As to this weight item in the schedule, a mere percentage should be sufficient, and in the two examples previously recited in part 5 the weights would be 45 percent $\frac{(5{,}000 \times \$10)}{\$110{,}000}$ and 45 percent $\frac{(200 \times \$300)}{\$132{,}000}$ respectively.

Not only must the fee schedule be available for "public inspection," presumably meaning review by anyone who requests it, but the proposed regulations would also require a practice to furnish a copy of it to any person upon request. This additional requirement will undoubtedly upset many doctors.

Other Matters

There are also some more specific provisions on pricing of new services or products, on a physician's moving his practice to a new area, and on setting fees when several doctors combine into a new group practice or when a doctor joins an existing group. Furthermore, the proposed regulations set out specific items the Cost of Living Council will consider in reviewing requests for exceptions to the rules—requests to increase fees beyond the stated limits. Finally, the described rules do not apply to HMOs or to physicians who earn 75 percent or more of their income from services to HMO subscribers, for there are entirely separate new rules for HMOs. All of these matters are not described herein in the belief that I have confused, frustrated, or angered my readers enough, although these additional provisions will be important to many practices.

The proposed new rules, which the council said "simplifies" the fee control system as it applies to medical practices, will more likely have the opposite effect. Thus, while apologizing for the frustrated nature of my article, may I respectfully say "Don't blame me."

PHASE IV RULE POST THIS!

To my patients. . .

In Compliance with Cost of Living Council regulations, a schedule of my fees is available at this office upon request.

_____

(Signature)

Member, Pennsylvania Medical Society

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

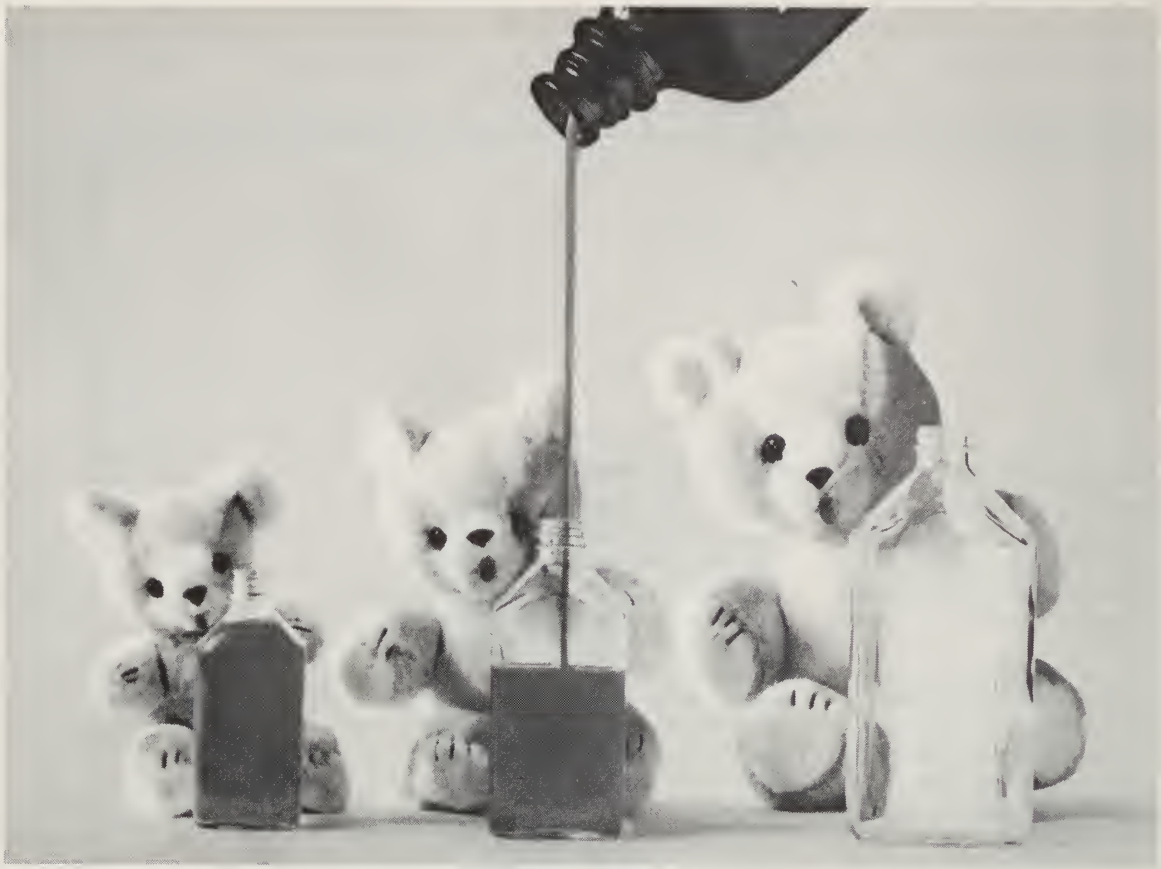
Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005



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M.D.s in the news

JONATHAN O. COLE, M.D., has been appointed chairman of the department of psychiatry at Temple University Health Sciences Center. He was formerly superintendent of Boston State Hospital. Prior to assuming that position, he had initiated and served on the psychopharmacology program at the National Institute of Mental Health from 1956 to 1967.

DR. COLE

DR. KOVNAT

PAUL J. KOVNAT, M.D., associate professor of medicine at Medical College of Pennsylvania, has been appointed associate dean of the college. He will coordinate the planning of undergraduate and residency programs in all primary care disciplines.

HERBERT S. BOWMAN, M.D., Harrisburg Hospital hematologist, was one of two Americans invited to lecture at the International Red Cell Symposium at the University of Toronto in October. He discussed anemias affecting the Amish people.

The Homeopathic Medical Society of Pennsylvania has honored SAMUEL FRIEDMAN, M.D., Scranton, for his sixty-three years of medical practice. Dr. Friedman served as chief surgeon at the former Hahnemann Hospital in Scranton for twenty-five years.

JACK EDEIKEN, M.D., professor of radiology and chairman of the department at Thomas Jefferson University, Philadelphia, delivered the second A. Z. Ritzman Memorial Lecture at Harrisburg Hospital recently. His topic was protein manifestations of hyperparathyroidism. He is a fellow in the American College of Radiology and is certified by the American Board of Radiology.

JOHN C. GAISFORD, M.D., Pittsburgh, has been elected second vice president elect for the American College of Surgeons.

JAMES C. GIUFFRE, M.D., director of St. Luke's and Children's Medical Center, Philadelphia, has been honored with an award from the Philadelphia Graduate Club for his work in the field of drug addiction.

STANLEY D. CONKLIN, M.D., Sayre, has been honored by receiving the first Distinguished Citizen Award from the General Sullivan Council of the Boy Scouts of America. Dr. Conklin was president of the Bradford County Medical Society for twenty-eight years. He also served for five years as chairman of the Robert Packer Hospital Board of Governors and has been a member and president of the Donald Guthrie Foundation for Education and Research.

MEHDI B. JAVAN, M.D., Westmoreland, has become a fellow of the American College of Surgeons. He is also a diplomate of the American Board of Thoracic Surgeons.

M. A. SAMAD, M.D., and M. MUNIR, M.D., both of Shamokin Dam, have been designated diplomates of the American Board of Internal Medicine.

H. R. DAILEY, M.D., Sharpsburg, has been designated chairman of the department of obstetrics and gynecology at St. Francis General Hospital in Pittsburgh.

News from the Medical College of Pennsylvania notes several new appointments. TOBY ENGEL, M.D., assistant professor of medicine, has been named director of the hospital's medical intensive care unit. JAMES P. BOLAND, M.D., associate professor of thoracic surgery and coordinator of geriatric surgery, has assumed responsibility for the surgical unit of the intensive care unit. JAMES O. FINNEGAN, M.D., assistant professor of surgery, has succeeded Dr. Boland as chief of the MCP surgical service at the VA Hospital.

EDMOND J. BIANCARELLI, M.D., Jessup, was honored at a testimonial dinner recently by his community in tribute to their only physician.

WALLACE F. BENJAMIN, M.D., emergency room physician at the Robert Packer Hospital in Sayre, has received the Pennsylvania Meritorius Service Medal for his work in organizing temporary medical facilities at the Scranton-Wilkes-Barre airport during the 1972 flood.

ALEXANDER M. MINNO, M.D., Pittsburgh, has been designated president elect of the Alumni Association of the Lahey Clinic, Boston, Mass.

CHARLES E. MACKENZIE, M.D., staff surgeon at Warren General Hospital, has been certified by the American Board of Surgery.

Participants at the annual convention of the Homeopathic Medical Society of the State of Pennsylvania at Hotel Hershey, September 25-27, 1973, are shown above. Standing (left to right) are Edwin McKinnon, M.D.; Robert Fulford, D.O., and Walter Kepler, M.D., Havertown, who was installed as the new president of the society. Seated (left to right) are Furman Kepler, M.D.; Benjamin Goldberg, M.D.; and Josephine Favini, M.D., Scranton, outgoing president.

Two faculty members of the Milton S. Hershey Medical Center, Pennsylvania State University, have been inducted as fellows of the American College of Surgeons. They are ROBERT B. GREER III, M.D., chief of orthopedic surgery, and G. FRANK O. TYERS, M.D., assistant professor of cardiothoracic surgery. Dr. Tyers presented two papers recently on internal cardiac pacing and myocardial hypothermia when he attended the Congress of the International Surgical Society and the Congress of the International Cardiovascular Society in Barcelona, Spain. They are in press in the *Journal of Thoracic and Cardiovascular Surgery*.

HERBERT L. FRANK, M.D., has been named director of anesthesiology at Harrisburg Hospital. Dr. Frank is certified by the American Board of Anesthesiology. He is a member of the American and New York Societies of Anesthesiologists, the American Medical Society of the Netherlands, and the International Anesthesia Research Society.

Two Medical College of Pennsylvania clinical associate professors in the department of obstetrics and gynecology have been elected to positions in the American Society for Colposcopy and Colpomicroscopy. ALBRECHT W. SCHMITT, M.D., is president and ALMA L. YOUNG, M.D., treasurer.

RICHARD E. GIBBONS, M.D., Media, has been elected president of the Philadelphia County Medical Society's Center City Branch.

THOMAS D. DUANE, M.D., has been named ophthalmologist-in-chief at Wills Eye Hospital and Research Institute. He will continue to serve as chairman of the department of ophthalmology and chief of service at Thomas Jefferson University's Jefferson Medical College and Hospital.

DR. DUANE

DR. FREIWALD

MILTON J. FREIWALD, M.D., Philadelphia, has been named ophthalmologist to the regional office of Philadelphia, Bureau of Disability Insurance Determination, U.S. Social Security Administration. He is a member of the attending staff at Albert Einstein Medical Center (Northern Division), is a diplomate of the American Board of Ophthalmology, and a fellow of the International College of Surgeons.

NANCY N. HUANG, M.D., professor of pediatrics at Temple University School of Medicine, is the recipient of the 1973 Service Award of the American Lung Association of Philadelphia and Montgomery County. She is director of the pulmonary disease and cystic fibrosis programs at St. Christopher's Hospital for Children and of the microbiology research laboratory.

ALMA DEA MORANI, M.D., Philadelphia plastic surgeon, has been honored by being named a Distinguished Daughter of Pennsylvania. She is president of the Medical Women's International Association.

The American College of Preventive Medicine has named two Pennsylvanians to serve as officers. KENNETH D. ROGERS, M.D., Pittsburgh, is vice president for general preventive medicine. NORMAN WILLIAMS, M.D., Philadelphia, is secretary-treasurer.

DORIS HOWELL, M.D., Philadelphia, has recently joined the staff of the Association of American Colleges. She will continue as professor of pediatrics, director of the pediatric research hematology laboratory, and senior consultant to the Learning Center at Medical College of Pennsylvania.

New vice president of the medical staff of the Philadelphia Psychiatric Center is NATHAN L. COMER, M.D., clinical assistant professor of psychiatry at Medical College of Pennsylvania.

New president elect of the American Society of Plastic and Reconstructive Surgeons is ROSS H. MUSGRAVE, M.D., clinical associate professor of plastic surgery at the University of Pittsburgh Medical School and clinical coordinator of the university's cleft palate research center. Dr. Musgrave is a member of the board of directors of the Allegheny County Medical Society.

PENNSYLVANIA MEDICINE new members

ALLEGHENY COUNTY:

Marvin A. Bloom, M.D., 1411 Grandview Ave., Apt. 305, Pittsburgh 15211.
Margaret I. Chepko, M.D., 5887 Saltsburg Rd., Verona 15147.
Farhad M. Contractor, M.D., Allegheny General Hospital, Pittsburgh 15212.
John W. B. Franklin, M.D., St. Margaret's Memorial Hospital, Pittsburgh 15201.
Eduardo Chua Lu, M.D., 4209 Main St., Pittsburgh 15224.
Weerasak Sangrujee, M.D., 9066 Perry Highway, Pittsburgh 15237.
Ralph Schmeltz, M.D., 1409 Raven Drive, Pittsburgh 15243.

BEAVER COUNTY:

Roman Y. deJesus, Jr., M.D., 315 Connecticut Ave., Rochester 15074.
Tulsidas N. Ragoowansi, M.D., 114 Behrend Ct., 22nd Ave., Beaver Falls 15010.
Beaver Falls 15010.
Paul A. Pupi, M.D., 1400 Seventh Ave., Beaver Falls 15010.

BERKS COUNTY:

Barry Bub, M.D., 1141 Walnut St., Reading 19604
John J. Keveney, Jr., M.D., 3700 Reiff Place, Reading 19606.
John F. Pifer, D.O., 63 N. Fourth St., Hamburg 19526.
Ratnakar S. Shetty, M.D., 210-K Mansion Dr., Shillington 19607.
Frank J. Szarko, M.D., Reading Hospital, Reading 19601.

BLAIR COUNTY:

Ralph C. Macek, M.D., 116 Union Ave., Altoona 16602.
Young Wung Rhee, M.D., Community Mental Health Center, Altoona 16603.
Mary E. Tipton, D.O., 421 Sixth Ave., Altoona 16601.
Eardly K. Wickramasinghe, M.D., Mercy Hospital, Altoona 16603.

BUTLER COUNTY:
Romeo H. Bella, M.D., Butler County Memorial Hospital, Butler 16001.

CHESTER COUNTY:
Herbert P. Adams, M.D., 1410 Russell Rd., Paoli 19301.
Joseph G. White, M.D., 139 E. Marshall St., West Chester 19380.

CLEARFIELD COUNTY:
Sen Hsiung Jone, M.D., 607 Daisy St., Clearfield 16830.

CRAWFORD COUNTY:
Joseph G. Piroch, M.D., Brooks Rd., R.D. 4, Meadville 16335.

DAUPHIN COUNTY:
John R. Freshman, M.D., 1719 N. Front St., Harrisburg 17102.
Marietta A. Banogon, M.D., 115 North St., Harrisburg 17101.
Michael E. Callahan, D.O., Harrisburg Hospital, Harrisburg 17101.
Edward B. Fitzgerald, M.D., 520 Hillcrest Rd., Hershey 17033.
David R. Halbert, M.D., Milton S. Hershey Medical Center, Hershey 17033.
Janusz Miszerak, M.D., 438 Sioux Dr., Mechanicsburg 17055.
Gary G. Nicholas, M.D., Milton S. Hershey Medical Center 17033.
Jay M. Nissley, M.D., 2516 N. Fourth St., Harrisburg 17110.
Franklin T. Seidlich, M.D., 5071 Stacey Drive East, No. 204, Harrisburg 17111.
Kenneth H. Yuska, M.D., Milton S. Hershey Medical Center, Hershey 17033.

DELAWARE COUNTY:
James B. Bell, Jr., M.D., The Media Clinic, Media 19063.
Dominador Q. Falguera, M.D., 506 Gainsboro Rd., Drexel Hill 19026.
John J. Firpo, Jr., M.D., 211 Shadeland Ave., Lansdowne 19050.
Leo G. Frangipane, Jr., M.D., 152 Kenilworth, Newtown Square, 19073.
Ahmed A. Hidayat, M.D., 151 Bishop Ave., Apt. F-24, Secane 19018.
Anmar A. Jamali, M.D., 330A East South Ave., Norwood 19074.
Edward McLaughlin, M.D., 824 Upton Way, Somerdale, N.J. 08083.
Donald E. Red, M.D., 850 Tall Oaks Rd., Radnor 19087.
David K. Saland, M.D., 2 Chester Pike, Ridley Park 19078.
Steven Secunda, M.D., 1050 Baltimore Pike, Springfield 19064.

ELK-CAMERON COUNTY:
Cecilio V. Delgra, M.D., 516 Market St., Johnsonburg 15845.

ERIE COUNTY:
Alan C. Harter, M.D., 2901 E. Lake Rd., Erie 16511.

JEFFERSON COUNTY:
Richard Thames, D.O., 115 Jenks Ave., Punxsutawney 15756.
Tai Young Yoo, M.D., Dubois Deposit Bank Bldg., DuBois 15801.

LANCASTER COUNTY:
Chang Yough Kim, M.D., St. Joseph Hospital, Lancaster 17604.
Richard H. Niemeyer, M.D., 154 E. Main St., Leola 17540.
William A. Raich, M.D., 520 N. Duke St., Lancaster 17602.
Alan S. Peterson, M.D., 100 Wellington Rd., No. 2, Lancaster 17603.

LEBANON COUNTY:
Ronald M. Legum, M.D., 618 Cornwall Rd., Lebanon 17042.
Fotis G. Mystakas, M.D., 229 S. Fourth St., Lebanon 17042.

LUZERNE COUNTY:
Anthony J. Turchetti, M.D., 165 East Eighth St., Wyoming 18644.
Walter Wartonick, M.D., 7 Park Lane, Mountaintop 18707.
Dennis J. Zeveney, Jr., M.D., 75 Spruce St., Mountaintop 18707.

McKEAN COUNTY:
Cecilio C. Dee, M.D., Bradford Hospital, Bradford 16701.

MERCER COUNTY:
Tong Ho Ham, M.D., 1965 Shenango Valley Freeway, Sharon 16146.

MONROE COUNTY:
Robert F. deQuevedo, M.D., 175 E. Brown St., East Stroudsburg 18301.
Mark Pliskin, M.D., 206 E. Brown St., East Stroudsburg 18301.

MONTGOMERY COUNTY:
Barry L. Singer, M.D., 1464 Ft. Washington Ave., Ambler 19002.

MONTOUR COUNTY:
Ronald W. Callenberger, M.D., Geisinger Medical Center, Danville 17821.

NORTHAMPTON COUNTY:
Douglas F. Turtzo, M.D., 38 E. Pennsylvania Ave., Pen Argyl 18072.

NORTHUMBERLAND COUNTY:
Manuel C. Palao, M.D., 800 Ostrum St., Bethlehem 18015.
Jonathan Warren, M.D., 1810 Washington Bldg., Easton 18042.

PHILADELPHIA COUNTY:
Milton H. Kannerstein, M.D., 1103 Spruce St., Philadelphia 19107.
Herbert J. Kauffman, M.D., 215 Cherry Lane, Wynnewood 19096.
Michael A. Maidoff, M.D., 235 Chamounix Rd., Philadelphia 19087.
George J. Murphy, M.D., 6441 Chelwynde Ave., Philadelphia 19142.
Ronald S. Banner, M.D., 302 Preston Rd., Flourtown 19031.
Heng Yu Chen, M.D., 116 Highland Drive, Titusville 16354.
Juh-Huey Chen, M.D., 403 S. Fortieth St., Philadelphia 19104.
Richard S. Glick, D.O., 3601 Conshohocken Ave., Philadelphia 19131.
Richard D. Hockstein, D.O., 1109 Ashbourne Rd., Cheltenham 19012.
Richard Z. Kondratowski, M.D., 828 Conshohocken St., Gladwyne 19035.
Alan J. Marcus, D.O., 515 W. Chelten Ave., No. 302, Philadelphia 19144.
Joseph M. Rodolico, M.D., 2216 S. Broad St., Philadelphia 19145.
Francis J. Shea, M.D., 3401 N. Broad St., Philadelphia 19140.
N. C. Shyamalan, M.D., 2 C. St., Bernard Hall, Darby 19023.
James W. Slavin, M.D., 510 Waring Rd., Elkins Park 19117.
Yung-Doo Song, M.D., 4000 Gypsy Lane, No. 245, Philadelphia 19145.
Jonathan L. Stolz, M.D., 4000 Gypsy Lane, No. 405, Philadelphia 19144.

WASHINGTON COUNTY:
David C. Leslie, M.D., 37 Highland Ave., Washington 15301.
Maude V. Vance, M.D., Centerville Clinic, R.D. 1, Fredericktown 15333.

WESTMORELAND COUNTY:
Pittagore Hattoum, M.D., Monsour Hospital, Jeannette 15644.
Josef Krauze, M.D., Kiski School, Saltsburg 15681.
Edward L. Williamson, M.D., 910 E. Pittsburgh St., Greensburg 15601.

PENNSYLVANIA MEDICINE editorials

Ways to judge competence

It has been proposed that recertification or relicensure be used as a method of insuring the clinical competence of physicians. With the volume of medical literature now being produced and the rapid advances being made in the medical field in general, it is not an unreasonable desire on the part of the patient to ask that his physician be cognizant of newer methods and have the ability to use these skills should the need arise. Although most physicians do follow these advances through clinical conference attendance and self-learning, there has been an increasing demand that the medical profession produce solid evidence of this. Recertification is one method that would provide the sought-after evidence.

Having decided that periodic evaluation is an assurance of competence, we are then faced by the question of how this can best be accomplished. Written examinations given about every six or seven years is a possible partial solution. Since the half-life of journal articles is approximately five to fifteen years, varying with the specialty field, a seven year reevaluation would be a fair gauge of the physicians current clinical knowledge. This, in itself, would not be sufficient because it shows only what the physician knows. It does not indicate whether he has applied his newly acquired knowledge in practice. It becomes necessary then to find a means by which we may also look at the physician's day-to-day activities. The medical audit is a tailor-made answer in that it provides an accurate record of performance in daily patient care through use of the medical record. An examination for knowledge and an audit for performance rating taken together should, in theory, provide an index to the physician's competence.

Competence may also be judged by peer review. Questions of alleged unethical conduct ought to be investigated by state medical societies and appropriate action taken. Findings should be publicized. Group practices tend to be a microcosm of state or county peer review in that an inefficient, inept, or incompetent physician will not survive in such a setting.

The actual structuring of such a system poses certain problems and obstacles. Who should be responsible for conducting the examination? What happens to the physician who fails to pass? Should failure be cause to revoke board certification?

First, and most important, the medical profession should take the lead in developing the system and prevent, if possible, judicial review based on the number of lawsuits against a physician. Were this to happen, many of our specialists would join the ranks of the unemployed. We have the agencies, either through the certifying boards or state licensing bureaus, to implement a suitable program. Second, the system should be *nonpunitive*. Initial failure should not be cause for revocation of either board certification or licensure, but should be used constructively to indicate either weakness or strength in a given area. As with the medical audit, recertification can be used in the continuing education process in that it reveals deficiencies, which spark educational programs, which lead to better clinical performance and, hoepfully, better patient care.

Improved patient care. That is the aim of recertification.

David A. Smith, M.D.
Medical Editor

PENNSYLVANIA MEDICINE correspondence

On clinical laboratory rules

The following is a copy of a letter sent to the Secretary of Health by Dr. Ingaglio, who is a member of the Council on Governmental Relations for the State Society.

Honorable J. Finton Speller, M.D.
Secretary of Health
Commonwealth of Pennsylvania

Dear Secretary Speller:

As a practicing physician I have occasions when some problems of the Commonwealth become very real for me and my colleagues. I am calling attention to the Pennsylvania Clinical Laboratory Law and the implementation of this law. Though I agree that standards of laboratory testing should be high, I do not feel that the outlawing or the prohibitive regulations for screening tests in office practice should come about.

To begin with, this would seriously strap the primary care physician and the internist especially in that he would have to refer out all lab work. This would drive the cost of care up and deprive a lot of people who could not afford the value of these tests. To be sure, not all physicians live in large metropolitan areas where laboratories or such services are available. Many live in smaller communities or even in rural settings and these tests mean the difference between hospitalization or outpatient or office follow-up. The cost of the former is much greater. Though improving the standards are necessary, should the foresight of a greatly expanded core of primary care physicians not be considered since this would be an area of reducing hospital inpatient days?

In the November 21, 1973, issue of *Medical Tribune* is an article on Britian's National Health Service at twenty-five years. In it they mention the development of the Royal College of General Practice which has broadened its scope in taking over more of the care of the postoperative and family care of the patient than is presently done in our own primary care programs. For example, a patient discharged from the

hospital after a phlebothrombosis or some embolic phenomenon could be less expensively followed in the office if his primary care physician could do a prothrombin time. Likewise G. C. cultures in the office could have a lot of meaning in controlling VD. Blood sugar determinations can help plot the course of the diabetic. Where would most of us be if these tests could not be done? What costs to the patient, the third party carrier, and the supporting governmental agencies would be incurred if everything was sent to the super lab? What standards of accuracy do we need in office laboratory work? Is there any merit to a blood sugar being read at 280 or 260 mg/100 cc when you know that the patient is way out of line? Is there any merit to knowing that a prothrombin time is 33 percent or 36 percent of normal when it is the trend and the range that is being followed? How much supervision is needed in "cook book" procedures when the real standarization rests in the equipment and the reagents?

I would like to address myself to you on these matters, because you are a physician. Should we not consider the entire panorama before a seriously limiting law is passed?

Philip E. Ingaglio, M.D.
Philadelphia

Certain pharmacy board rules affect physicians

(Continued from page 16)

patient shall designate for his safety and convenience, or by means of an employee, the mails, or common carrier.

Caution Legend Drugs

If a pharmacist refills a caution legend drug, a record of each refill showing the date of each refill and the name or initials of the dispensing pharmacists and the quantity dispensed, if different from the original quantity, must be indicated on the back of the prescription or recorded in records elsewhere.

Unauthorized Use Prohibited

No pharmacists may knowingly fill or refill any prescription for a legend, caution legend, or nonproprietary drug or device if he knows or thinks it is for use by someone other than for whom the prescription was written.

Fail-Safe Clause

A pharmacist shall not be required to fill or refill a prescription if in his professional judgment in the interest of the safety of the patient, it should not be filled or refilled.

Hospital Chart Orders

An "order" entered on the chart or medical record of a patient in an institution on an overnight basis or on the chart or medical record of a patient under emergency treatment in an institution by or on the order of a practitioner authorized by law to prescribe drugs or devices, shall be considered to be a prescription if such medication is to be furnished directly to the patient for self-administration.

It is the responsibility of the physician to see that the chart or medical record contains all the information required for a "prescription" and that it is signed by the physician himself at the time the drug is given or, if he is not present, on his next visit to the institution.

No registered pharmacist may honor a prescription or order in an institution or hospital unless it is an original prescription or order or direct copy thereof issued by the physician who may be using electronic or computerized equipment.

No Supplied Prescription Blanks

No pharmacist, pharmacy owner, or pharmacist manager shall be permitted to provide a physician with prescription blanks bearing a pharmacist's name or the name or address of the pharmacy thereon.

Pharmacy Advertising Regulated

(1) Only licensed pharmacists and pharmacies may advertise.

(2) Advertising may not promote the sale of Schedule II substances or barbiturates and their compound.

(3) Any advertisement of a prescription must be for a commercially reasonable quantity. Where the price of a quantity of a prescription drug is advertised, the price of one dosage unit or of the smallest saleable quantity shall be shown.

(4) In advertising using percentage numbers, such as 10 percent off, the pharmacy must state or publish a price list from which the percentile prices are derived so that the patient knows exactly what his cost will be.

Renewal of Prescriptions

A pharmacist may only renew a prescription after a reasonable time has elapsed from the date of filling and when he might expect that the original prescription would be consumed.

Copies of Prescriptions Permitted

The patient shall have the right to request a copy of his original prescription, but copy shall clearly indicate on its face that it is a copy and may not be used to obtain a new prescription order or refill.

Prescriptions on file with pharmacists must now show the following:

(1) The name of the patient;

(2) The name and address of the physician prescribing;

(3) The name and quantity of the drug prescribed;

(4) Directions for its use;

(5) The date the prescription was compounded and dispensed;

(6) The name or initials of the dispensing pharmacists;

(7) When required by law, the address of the patient, the date the prescription was issued, and the prescriber's BNDD number.

Fair Trade Act Upheld

Any violation of the Pennsylvania Unfair Trade Practice Act is a violation of the regulations.

☑ ------- *Presidents*
☑ ------- *Presidents Elect*
☑ ------- *Secretaries*
☑ ------- *Executives*

of County Medical Societies

Mark April 24 and 25
on your Calendar

for the [redacted]

Host Inn *Harrisburg*

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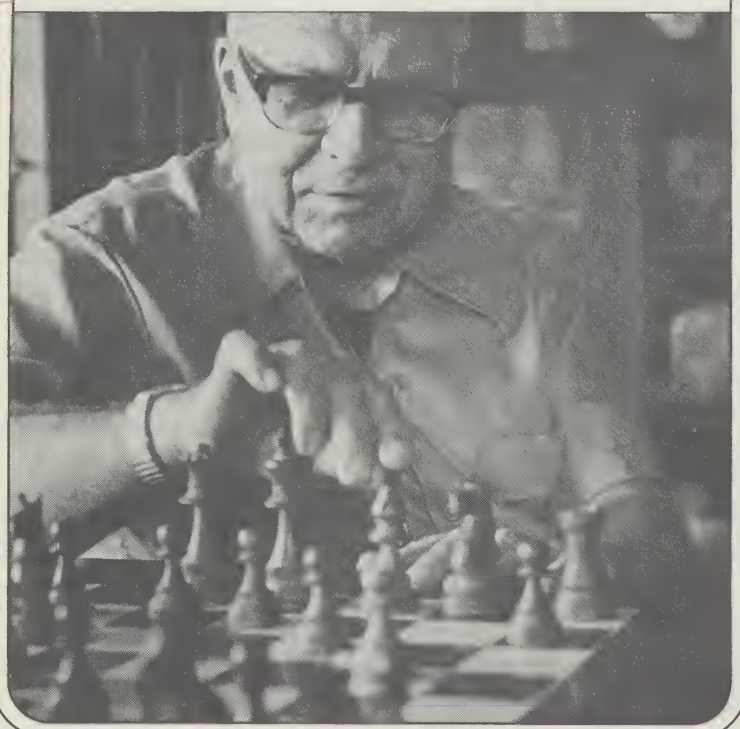

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***AVAILABLE ON REQUEST:** Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

TRAUMA!

Diagnosing facial fractures

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The unique identifying characteristic of a man is his face. Preservation of its functions and form may be essential to an individual's recognition. The restoration of a mutilated face may require great technical skill and a sense of proportion and symmetry.

Although remarkably impressive in appearance, few facial injuries are life threatening. The greatest risk to an individual lies in mandibular fracture. If the fracture is such that the tongue is no longer supported anteriorly, it may fall back into the pharynx producing upper airway obstruction. Obviously, associated intracranial or cervical spine injuries may prove the most significant in terms of the patient's prognosis. At times the definitive repair of facial injuries may be deferred for up to two weeks until other more critical problems have been treated.

The nasal bones are the most frequently injured facial bones, followed by the zygoma and mandible. As in other bones, the nature of the fracture may be: open, closed, greenstick, comminuted, displaced or nondisplaced. The location of central facial fractures is described by dividing the face into three regions (LeFort I, II, and III).

Facial fractures are diagnosed by the usual methods that apply to other bony injuries: inspection, palpation, and with appropriate radiographs. Often the fracture and displacement is more evident upon examination than by x-ray. History may be helpful particularly if the patient has noted a change in occlusion. Trismus and mandibular deviation may be additional clues.

Palpation should be performed in a systematic manner bilaterally to facilitate comparison of subtler deformities. All of the bony parts should be felt including the anterior antral walls and the hard palate with the examining finger in the mouth. Localized tenderness, ecchymosis, and bony notches or overriding will aid in the diagnosis.

Nasal fractures and septal injuries will be characterized by a history of epistaxis. Deviation of the septum and displacement of the nasal bones may be evident. Submucosal hematomata if present must be evacuated. The most useful x-ray to diagnose this injury is the occlusal film showing the nasal bones and bony septum in longitudinal section.

Zygomatic arch fractures occur as isolated injuries when the patient has been struck forcibly with a small object which imparts a direct blow to the arch alone. A palpable defect is evident unless obscured by early swelling. The impactions and displacement of the arch may produce severe trismus due to pressure on the coronoid process or more often impingement on the temporalis tendon and muscle. The Townes view is the most satisfactory x-ray projection for these injuries.

Malar fractures can be difficult to diagnose depending upon the amount of displacement and the degree of impaction. Classically separation occurs at the frontal zygomatic suture line, through the medial orbit and across the anterior antrum. Infraorbital nerve anesthesia usually results and diplopia may or may not occur depending upon the condition of the orbital floor. Trismus results if impaction has occurred to such an extent that the arch presses inward upon the temporalis tendon and muscle. Subcutaneous emphysema may be noted about the eye and be worsened by blowing the

(Continued on page 40)

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special report

. . . On peer review activities

The Council on Medical Service has been involved with various aspects of peer review for many years. The current review activites, monitored by the council, are in the form mandated by a Board of Trustees action in January 1969. The program relies on the voluntary services of committees of physicians appointed by the Pennsylvania or regional chapters of twenty-one recognized specialty societies. Each of these committees, composed of five to seven physicians representing various areas of the state, is called upon from time to time to review cases submitted to the Pennsylvania Medical Society by health insurance carriers, government health agencies, patients, and physicians.

Cases submitted for review fall into two categories: Appropriateness of service and reasonableness of the charge for that service. Following a careful review of all the information provided, an advisory opinion is rendered and conveyed simultaneously to the initiating party and the attending physician and insurance carriers. Every effort is made to provide for a fair and proper handling of the matter. The Society accepts no cases where there has not been some attempt at settlement on the physician-carrier or patient level.

Charges for this review program include only administrative costs incurred in conducting the review, which involve staff time, travel expenses for physicians in attending review meetings, etc.

It is the hope of the Society to work closely in the development of medical care foundations so that the peer review function can be included in the overall program.

Total parenteral hyperalimentation versus conventional techniques

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Studies of total parenteral hyperalimentation by Dudrick, et al[1] demonstrated positive nitrogen balance associated with normal growth and development in beagle puppies when compared with their littermates fed by conventional means. Clinical application in infants, children, and adults, have produced similar results.[2] Subsequently, studies have proven that total parenteral hyperalimentation has greatly reduced the morbidity and mortality of many serious pediatric and adult illnesses.[3-5] A controlled clinical study comparing total parenteral hyperalimentation and conventional feeding techniques between premature twins was presented to us at St. Christopher's Hospital for Children making this the basis of our report.

Figure 1. Twin A at birth weighing 1340 grams.

Case presentation

Premature twins, product of an uneventful twenty-eight week gestation from a Gravida III Para II mother, were delivered spontaneously at the Community Medical Center at Scranton, Pennsylvania, without any difficulties. Twin A (Fig. 1) weighed 1340 grams at birth and had an Apgar score of eight in five minutes. Abdominal distension and bile-stained vomitus was noted on the second day of life, and an x-ray study showed an upper small bowel obstruction compatible with jejunal atresia (Fig. 2). He was then transferred to St. Christopher's Hospital for Children. Because of the low birth weight, it was decided to use total parenteral hyperalimentation prior to definitive surgery.[10] A Silastic catheter (Dow Corning Medical grade tubing No. 602-155) which accepts a No. 22 gauge blunt needle was threaded to the superior vena cava

Figure 2. Obstruction series of Twin A showing distension of the stomach and upper small bowel with air-fluid levels on PA view.

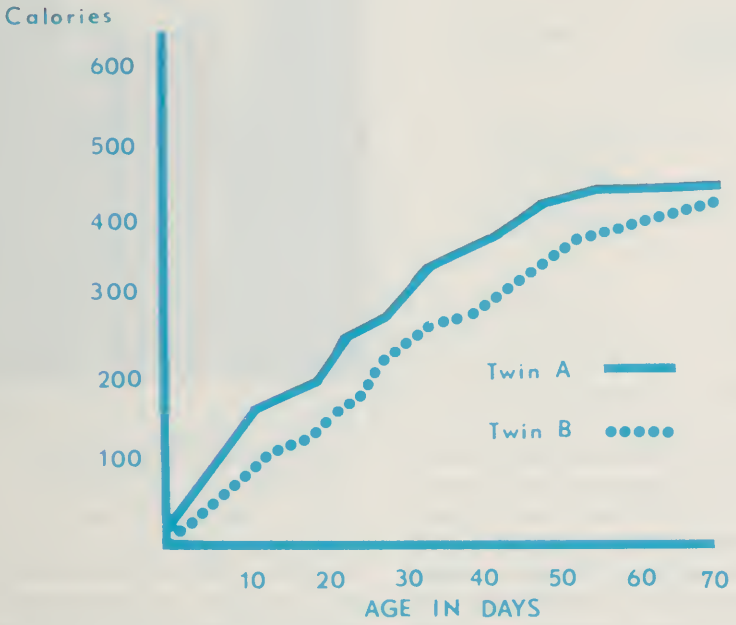

Figure 4. Comparison of daily caloric intake.

Figure 3. A chest x-ray taken in the operating suite showing the tip of the catheter in the right atrium. The catheter was pulled out two centimeters so as to allow the tip to be in the superior vena cava.

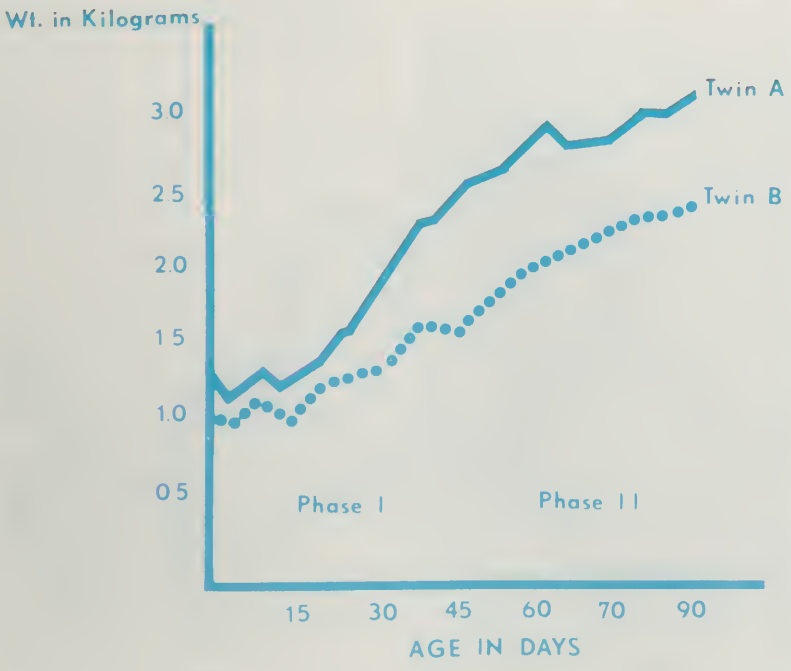

Figure 5. Comparison of the daily weights.

Figure 6. Twin A at age 36 days weighing 2420 grams and just prior to corrective surgery.

TABLE I
Comparison Between Total Parenteral
Hyperalimentation Mixture and Standard Formula
(Similac 20)

Parameter	*Parenteral Hyperalimentation (20% Amigen-Dextrose mixture) (Baxter Laboratories)	Similac 20
Protein	3.4 gm/100 ml	2.12 gm/100 ml
Carbohydrate	20 gm/100 ml	8.00 gm/100 ml
Fat	none	4.2 gm/100 ml
Calories	940 Cal./liter	720 Cal./liter
Non-protein calories	167 Cal./gm of Nitrogen (N)	203 Cal./gm of N
Calories required to gain 1 gm. body weight	4.6 Cal./gm	5.6 Cal./gm

*Electrolytes and vitamins were added as required.
Plasma was given at 20 ml/kg once a week.
Whole blood or packed red cell transfusions were given as needed.

via the external jugular vein under x-ray control in the operating room (Fig. 3). The remainder of the catheter that was not in the vein was looped in the subcutaneous tissue of the neck and exited through a stab wound in the anterior axillary line as described from a recently published article from our institution.[9] The composition of the hyperalimentation solution is standard and is listed in Table I. The daily caloric intake is graphically demonstrated in Figure 4. Figure 5 is a comparison of the twins' daily weights.

After thirty-six days of uneventful nutritional support via the central route, Twin A underwent corrective surgery with a weight of 2420 grams. (Figure 6). While awaiting corrective surgery, a nasogastric tube was in place and fluid losses were replaced appropriately. The second phase of the study commenced following surgery and this was considered the "stress period." Wound infection was noted on the fifth postoperative day, and this was treated with drainage and antibiotics. Oral feeding was tried on the eighth postoperative day, but vomiting recurred. During a vomiting episode, Twin A developed bradycardia and respiratory depression, and this responded to cardiopulmonary resuscitation which included the use of endotracheal intubation and a ventilator. Twin A recovered from this episode promptly, and total parenteral hyperalimentation was resumed. Anemia was noted during the study and this treated with repeated blood transfusions. Jaundice appeared late in the study, and this gradually disappeared without treatment. He also developed pathologic fractures (Fig. 7) late in the study and this responded well to adequate calcium, phosphorus, and Vitamin D therapy. At sixty-seven days of life the total parenteral hyperalimentation was discontinued, and Twin A weighed 3125 grams. Oral feeding was restarted and was tolerated well. After a transient weight loss, Twin A steadily

Figure 7. X-ray picture of both lower extremities showing the pathologic fractures of both tibia and fibula.

Figure 8. At age 80 days Twin A (left) weighed 3125 grams and Twin B (right) weighed 2246 grams.

Figure 9. At age 9 months Twin A (left) weighed 16 lbs. 9 oz. and Twin B (right) weighed 17 lbs. 4 oz.

TABLE II
Summary of the clinical comparison between the twins

	Twin A	Twin B
Initial weight	1339 grams	1252 grams
Lowest weight	1169 grams	1051 grams
Weight at the end of non-stress phase (36 days)	2423 grams	1428 grams
Weight at the end of stress phase (67 days)	3125 grams	2246 grams
Average daily weight gain	37 gm/day (Phase I)	18.4 gm/day
	22.6 gm/day (Phase II)	18.4 gm/day
Complications during study	Phase I (non-stress)	none
	a. none	
	Phase II	
	a. aspiration pneumonia	
	b. jaundice and anemia	
	c. wound infection	
	d. pathologic fractures	

gained weight, and he was discharged from the hospital on the eighty-eighth day of life with a weight of 3209 grams.

Twin B weighed 1252 grams at birth and had an Apgar score of five in five minutes. There were no gastrointestinal symptoms noted, and gavage feeding was instituted promptly. Standard formula (Similac 20, Ross) was used to maximally tolerated volume. Gavage feeding was continued for forty-seven days, and bottle feeding was commenced on the forty-eighth day of life. Twin B was discharged from the Community Medical Center in Scranton on the sixty-third day of life. At eighty days of life, Twin A weighed 3125 grams, and Twin B weighed 2246 grams (Figure 8). At nine months of age the twins had almost an identical weight (Figure 9).

Discussion

Twin A consistently received more calories and gained more weight than Twin B. This is best analyzed by dividing the study into two phases. Phase I ("non-stress period") is the first thirty-six days. During this phase, Twin A gained 37 grams daily, while Twin B gained 18.4 grams daily. Twin A received more calories than Twin B at a more constant, controlled, and at a maximally tolerable rate. The volume of tolerable feeding by Twin B is limited by a small gastric capacity and the dangers of prolonged and repeated gavage feeding.[6-8] At the end of phase I, Twin A weighed 2423 grams and Twin B weighed 1428 grams. Phase II ("stress period") is from the thirty-sixth to the sixty-seventh day of life of Twin A. The daily weight gain of Twin A was 22.6 grams, while Twin B's gain was 18.4 grams. At the end of phase II, Twin A weighed 3125 grams, and Twin B weighed 2246 grams (Table II). This data indicated that total parenteral hyperalimentation resulted in a more rapid weight gain even in the presence of major stress and its catabolic consequences. In the absence of stress (Phase I), the difference in weight is even more noticeable, favoring total parenteral hyperalimentation over conventional feeding regimen if weight gain is used as the primary criteria for comparison. The complications noted on Twin A are explained by a combination of "stress-producing factors" such as the surgery itself, the wound infection, the cardiorespiratory depression following aspiration; and perhaps prolonged use of the total parenteral hyperalimentation is a contributing factor.

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Summary

Premature twins with different clinical problems served as a controlled study comparing total parenteral hyperalimentation with conventional feeding technique. In the absence of stress, total parenteral hyperalimentation resulted in weight gain twice that of the conventional feeding regimen. When stress and its metabolic consequences were added to the study, the infant on total parenteral hyperalimentation still gained more weight than the "non-stressed twin." Gastrointestinal capacity is not a concern with total parenteral hyperalimentation and permits greater caloric intake at a more constant and tolerable rate. This study is consistent with the original studies of Dudrick, et al, on littermate beagle puppies. □

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Skin and fat atrophy complications of local steroid injection

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LOCAL steroid injection has become a popular procedure among physicians charged in the management of rheumatic and traumatic disorders of soft tissue. It allows for deliverance of a relatively low loss of steroid directly to the site of involvement with very little systemic overflow and frequently is followed by prompt and striking clinical improvement. However, a word of caution is proffered over the injection of depository forms at the intradermal and subcutaneous levels. The consequences form the basis of this report.

Figure 1. Skin atrophy following injection into distal lateral hamstring tendon for strain. Central scarred and atrophy hypopigmented lesion with peripheral hyperpigmentation which does tan when exposed to sunlight.

Various degrees of atrophy of skin and subcutaneous tissue have been reported following the experimental use of insoluble corticosteroid preparations with a typical evolutionary pattern seen in high intradermal injections consisting of vesiculation on an erythematous and indurated base followed by crust formation and eventual separation exposing a scarred, telangiectatic, alopecic, hypopigmented central lesion with peripheral hyperpigmentation (Figures 1 and 2). Such a lesion is usually permanent. Injections into low intradermal and subcutaneous tissues produce lesions of lesser severity, the latter at times consisting solely of fat atrophy which may persist indefinitely.[1]

The areas of leukoderma do not tan when exposed to sunlight and in the Negro may be quite striking (Figure 3).

The authors have observed pustule formation with a centrifugally advancing cellulite border during the early evolutionary lesional stages. While the immediate site of skin infection is minor, penumbral response is inordinately large and symptomatic and suggests a decreased host resistance. Prompt resolution of the inflammatory component follows the local application of warm compresses and administration of oral antibiotics. This complication, while inconstant, may exert a deleterious effect on the duration and/or extent of the steroid lesion.[2]

Though for the most part asymptomatic, the permanent atrophic deformity may be sensitive to external pressure as may be caused by a shoe or watchband. Most patient complaints are fostered by the unsightly appearance of the lesion, with women being considerably more vociferous than their male counterparts. Accordingly, it is suggested that the insoluble depository corticosteroid preparations be reserved for deep injections into joints, bursae, and muscle and the soluble forms used for injections into more superficial structures such as tendons and ligaments about the wrist, knee, ankle, and foot. □

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Figure 2. Steroid lesion over lateral midfoot with hyperpigmentation and atrophy as principal features. Note prominent veins.

Figure 3. Steroid lesion in a Negro. Leukoderma and scarring. Note depression of lesion caused by strophy of skin and subcutaneous fat.

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Rare case from windshield injury

Section of the hypoglossal nerve by penetrating glass

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THE following case is reported because of the rare selective injury of a cranial nerve in the neck by penetrating windshield glass and to emphasize to those who still do not believe in using seat belts that such an injury probably would not have occurred if the patient had available and had used a seat belt with a shoulder restraint.

Case Report

The patient, age eighteen, was riding in the right front seat of a Volkswagen. It was not fitted with a seat belt. His car stopped at an intersection and was struck broadside slightly forward of the driver's seat. The patient's head and neck penetrated the windshield. He was unconscious for a few minutes and remembers being taken to a hospital where multiple lacerations of the face and neck were sutured.

Figure 1. Healed lacerations of the face and neck ten months after penetrating windshield glass injury of the left hypoglossal nerve in the neck.

X-rays of the skull, facial bones, and neck were reported negative for fracture. The day of the accident the patient noticed difficulty in moving his tongue and in swallowing saliva. He had no other injuries and subsequently had cosmetic surgery for his facial lacerations.

I saw the patient ten months after the accident. He complained of difficulty in moving his tongue to the left and in swallowing saliva.

He had scars of the face and left anterior neck (Figure 1). He had no hoarseness. The examination was normal except for paralysis and atrophy of the left side of the tongue (Figure 2). When the patient attempted to protrude his tongue it deviated to the left, and he could not protrude it to the right. There was a slight decrease of the gag reflex on the left, but sensation to pinstick was present bilaterally in the soft palate and the upper oropharynx. Motor function of the sternocleidomastoid and trapezius muscles was normal. There was no bruit on auscultation over the scar and the carotid artery. From the position of the scar in the patient's neck and the neurological findings, it appeared most likely that the hypoglossal nerve had been selectively sectioned by a penetrating piece of glass during the windshield injury. The ninth or tenth cranial nerve may have been partially injured because the patient had had slight difficulty in swallowing. However, he had no hoarseness or anesthesia of the oropharynx or soft palate.

In view of the precise incision of the nerve by the glass, it was felt that the nerve ends might be in close apposition or possibly incompletely sectioned.

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Electromyography (EMG) of the tongue five months after the injury suggested some intact nerve supply to the left side of the tongue. The study was repeated three months later and one month before my examination and again showed incomplete denervation and improvement as compared with the EMG done three months previously.

In view of these findings, I decided to withhold nerve exploration. The patient did not return for further evaluation.

He was contacted in January, 1973, eight years after the injury. He stated that he felt fine, that the left side of the tongue was "still shrunken," and that he had difficulty in protruding it to the left. He had no trouble in swallowing or control of his saliva. He had no other complaints referable to the neck injury.

Figure 2. Patient attempts to protrude tongue directly forward. It deviates to the left because of paralysis of the tongue muscles on that side supplied by the left hypoglossal nerve. Note atrophy of left side of tongue.

Discussion

Aside from the apparent precise transection of the hypoglossal nerve by the penetrating glass, another unusual aspect of the injury was the apparent es-

cape from a serious laceration of the internal jugular vein, the internal carotid artery, and the ninth, tenth, and eleventh cranial nerves, which are in intimate relation to each other and to the vascular structures.

Fogelman and Stewart,[1] Stein and Seaward,[3] and Yoder et al[4] have reported large series of patients with stab wounds of the neck. Blood vessel injury was most common; injury of the brachial plexus, phrenic nerve, and autonomic nerves occurred only occasionally. None reported injury to the cranial nerves. Hubey states that the cranial nerves in the neck may be severed or contused in neck injuries but gives no statistics.[2]

Summary

A case is reported of a rare transection of the hypoglossal nerve in the soft tissues of the neck by penetrating glass from a windshield injury.

The sparing of severe injury to the internal carotid artery, the jugular vein, and the vagus nerve which were intimately close to the cut nerve shows that a penetrating sliver of glass can have the selective precision of a surgeon's scalpel.

The above injury probably would not have occurred if the patient had available and had used a seat belt with a shoulder restraint. □

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Diagnosing facial fractures

(Continued from page 33)

nose. Nasal bleeding can occur especially after a few days when the old blood accumulated within the antrum may drain intranasally spontaneously.

The stereo Waters view is most helpful in diagnosing this injury. The antrum on the involved side will be clouded or exhibit an air fluid level. The medial orbital, frontal zygomatic, and anterior antral fracture lines are usually evident unless the fracture is morbidly impacted.

The "blow out" fracture is a clinical diagnosis not a radiographic one. This injury which follows a compressive force to the orbital rim, like a fist or baseball, is characterized by diplopia, enophthalmus (before edema occurs), a lowered pupillary level on the injured side, and usually infraorbital anesthesia. The fracture lies across the orbital floor and may trap the inferior rectus muscle preventing upward lateral gaze. Major disruption of the floor leads to herniation of orbital fat into the antrum, loss of globe elevation, and restricted motion. The Waters view again is the most useful projection to study this area. Tomography can be helpful and at times, when the conventional PA tomograms are normal, lateral tomography may delineate the defect. At the time of surgery a forced duction test, attempting to move the globe, will demonstrate the entrappment by resistance to external superior rotation. Obviously entrapment of the muscles or herniation of orbital contents can occur in zygomatic fractures as well as orbital floor fractures.

Transverse maxillary fractures (LeFort I) often result from the patient's upper jaw striking a dashboard or steering wheel rim. The mobility of the upper alveolar rim and teeth as well as the readily palpable fracture line in the sulcus aid the diagnosis. The most helpful radiographic view is fronto-occipital anterior-posterior projection. Pyramidal central facial fractures (LeFort II) are less common in today's high speed transportation system than the LeFort I and III injuries. The lateral extensions of these fractures are often palpable and the central portion of the face moves with the central incisors. The Waters projection is valuable in the identification of the injury. Often an accompanying nasal septal and nasal bone injury will require treatment also.

The massive craniofacial separation (LeFort III) occurs most often as the result of the face forcibly striking a dashboard. Cerebrospinal fluid leaks may be present and must be recognized. Basilar skull fractures often result and may take precedence over any facial injury. Often infraorbital anesthesia does not occur. Multiple fracture lines may be palpated over the glabella, the lateral and medial orbital rims, and through the zygomatic arches. The sinus can be clouded and communication into the frontal sinus may occur.

Frontal ethmoid complex fractures can result from depressed frontal sinus fractures and in accompaniment with the LeFort II and III fractures. Cerebrospinal fluid leaks can result and can be diagnosed from the profuse clear drainage which contains no mucin and is positive when tested for sugar with one of the diabetic test tapes. The risk of ascending infection is great with these dural tears. Usually the interpalprebral distance is widened with these injuries and despite favorable treatment may remain as a conspicuous deformity.

Mandibular fractures are usually not hard to diagnose unless the injury is subcondylar. These high injuries may be masked by associate facial trauma and may be overlooked as not evident on standard facial bone and mandibular x-rays. The panoramic roentgenogram of the mandible is often the most rewarding single projection. Class I mandibular fractures have teeth in the mandible on either side of the fracture. Class II fractures posses teeth only in one segment and Class III injuries occur in the edentulous patient.

Deviation of the mandible on opening and closing, trismus, and malocclusion acknowledged by the patient are helpful diagnostic signs. Tenderness over the fracture and bleeding from about the teeth further help in the diagnosis.

In general facial fractures do not pose life threatening problems for the injured patient unless there is major bleeding in the pharynx or loss of tongue fixation and airway obstruction. Cerebrospinal fluid leaks can occur and may pose an avenue for serious infection.

The early repair of these injuries is of lesser importance than the general management of the seriously traumatized individual. Their reduction and fixation often can be delayed up to two weeks if the patient's general condition prevents earlier appropriate treatment.

Experience at Camp Firefly

Camping rewarding for diabetic children

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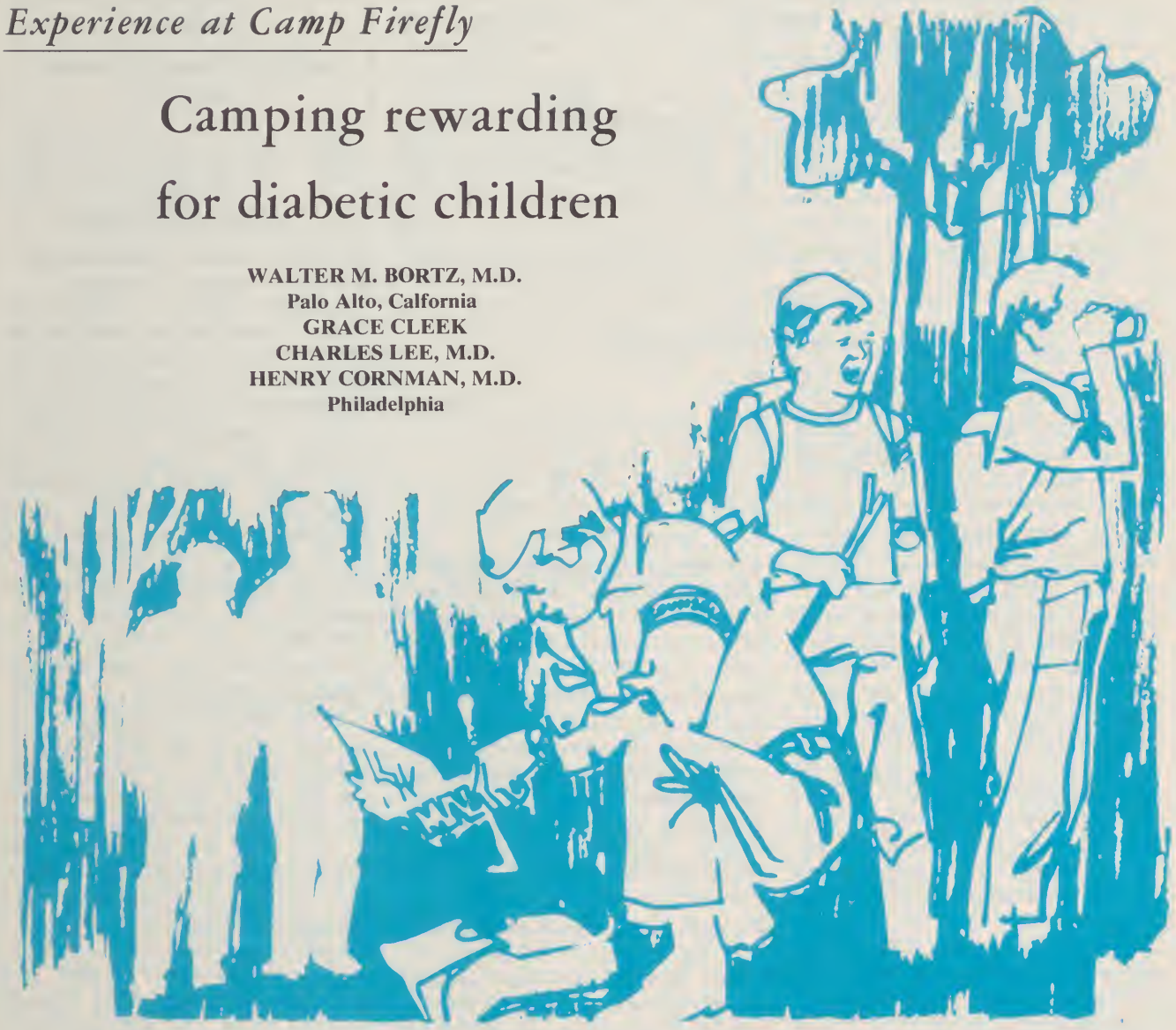


ONE OF the most rewarding opportunities available to the diabetic child is an experience at a summer camp. Such experience allows sharing with peers of common uncertainties, fears, resolves, hopes, and realizations. Although it is estimated that there are 100-150,000 juvenile diabetics in the United States,[1] the individual child with diabetes often senses a feeling of isolation. The camp experience allows a perspective to be gained that is scarcely attainable in any other way.

In recognition of this, a number of camps for diabetic children have been founded throughout the United States. Camp Firefly, near Schwenksville, Pennsylvania, was among the earliest of these and has now been in continuous operation since 1935. It is in the administrative charge of the Delaware Valley Diabetes Association and represents a principle activity of this organization.

Operationally there are two two-week sessions each summer for boys and two for girls. The charge for a campership is $210.00, and the parents are requested to pay this amount. However, many reductions and some no-charge situations prevail. No child is denied entrance for financial reasons.

There is a full-time physician coverage usually by pediatric or medical residents from Philadelphia hospitals as well as regular consulting visits by interested physicians. Around the clock

Dr. Bortz is a physician in internal medicine at the Palo Alto Medical Clinic in California and a clinical assistant professor of medicine at Stanford University. He was formerly at Lankenau Hospital, Philadelphia. Ms. Cleek is a technical assistant. Dr. Lee is senior physician at Chestnut Hill Hospital and past president of the Delaware Valley Diabetes Association. Dr. Cornman is assistant attending physician and acting chief of service at Bryn Mawr Hospital. He is also assistant instructor in medicine in the outpatient department at the Hospital of the University of Pennsylvania.

TABLE I

Enrollment by Age

	Girls									Boys								
Age	'64	'65	'66	'67	'68	'69	'70	'71		'64	'65	'66	'67	'68	'69	'70	'71	
6-9	21	16	19	13	11	10	14	13	117	19	18	19	21	11	10	21	11	130
10-14	33	44	41	41	39	32	43	40	313	32	32	31	33	33	35	27	30	253
15-17	4		4				1	1	10	4		2		1		2	3	12
+	3		2				1		6			1						1
									446									396

TABLE II

Age of Onset of Diabetes All Campers

1964-1971

Age	< 1	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Girls	8	12	33	24	20	54	77	34	73	44	29	24	11	4	0
Boys	5	25	30	35	48	38	41	36	43	38	29	14	7	5	1

nursing is provided with midnight checks of the campers for hypoglycemia as well as the services of a dietician and a medical technician. A typical camping program is offered with water and land sports, nature experiences, handicrafts, music, etc. All of this is blended with teaching the child to care for his diabetes under varying conditions of normal life and activity including intercamp athletic contests and overnight camping trips. At the conclusion of each camping period, the child's physician receives a report on the child's experience and diabetic control.

The camp philosophy is designed to afford an opportunity to study each child's diabetes while he is under close observation yet in a more normal setting than is ever possible in a hospital.

Study

Because of the unique opportunity afforded to observe a group of juvenile diabetics over a period of years, a survey was made of some of their personal identifying characteristics, aspects of their diabetes, and its management. The records of the children in camp for the years 1964-1971 were reviewed and these data compiled. In some cases the same child is represented repeatedly in the charts, as no effort was made to record consecutive camp attendance.

Table I indicates the enrollment for the eight years of the study. There were 842 campers in this period. Although the camp operates at close to capacity, there is generally room for a few additional boys and girls. Although our attendance figures cannot indicate prevalence of the disease, it is generally indicated that there is no sex predilection in juvenile diabetes.[1]

TABLE III

Duration of Diabetes All Campers

1964-1971

Years	< 1	1	2	3	4	5	5+
Girls	22	42	65	58	63	46	144
Boys	24	43	44	50	45	52	142

Whereas for the girls there seemed to be a peak age of onset of the diabetes between six and eight years of age, such was not apparent for the boys (Table II). White and Graham report in Joslin's *Diabetes Mellitus* that the peak incidence is at age eleven, which they point out is the inverse of the ratio of islet to total pancreatic growth.[1] Also, onset under one year of age is noted to be rare.[2] Years of duration (Table III) are seen to indicate that not only newly discovered diabetics, but also those of more prolonged contact, have sought out the camp experience.

It was thought that review of the types of insulin generally preferred might indicate some evolving pattern over this period of time, but no trend was noted. It is interesting to note that 33 percent of the children received only a single type of insulin rather than a mixture of insulins despite the generally held view that single insulin therapy is inadequate for control of most juvenile diabetics (Table IV). While it is the general habit to leave the child on the same insulin program as on arrival, this is frequently modified in an attempt to achieve better control. Because of the increased physical activity associated with the camp program, the number of units of insulin on arrival was frequently reduced during the stay at camp (Table V). The exceptions to this

TABLE IV

Types of Insulin

	Girls								Boys							
	'64	'65	'66	'67	'68	'69	'70	'71	'64	'65	'66	'67	'68	'69	'70	'71
NPH	8	15	13	10	8	13	22	11	20	13	11	12	12	14	12	9
NPH & R	24	19	21	19	27	15	24	27	15	14	19	26	15	15	18	19
L	9	9	7	4	5	2	2	5	7	9	11	6	2	4	6	3
L & R	9	7	12	10	3	2	5	5	7	5	4		3	1	4	3
UL	2	2														
UL & SL	5	4	1	2	1	3	2			2	1	1	1	1	0	1
L & UL	3		2	2	1		1		1	1	1	0	2	0	2	0
UL & R	1	3	3	1	1	2	1	1	1	0	0	1	3	2	3	3
PZI & R		1	3	1	2	1	2	2	0	0	2	0	0	0	1	1
G				1	1				0	3	1	1	0	1	1	1
L & SL		1	3	4	1	1		1	0	0	1	1	4	3	2	3
PZI		1							0							
Other						2		1	3	2	1	2	2	3	1	1

L = Lente SL = SemiLente G = Globin
R = Regular UL = UltraLente

TABLE V
Amount of Insulin

No. of Units	Girls		Boys	
	*	0	*	0
6-10	9	15	16	17
11-20	70	51	83	80
21-30	122	134	126	150
31-40	95	94	85	82
40+	148	150	83	62

* First week of camp experience
0 Second week of camp experience

usually represented children who came to camp on what proved to be an inadequate insulin dose at home.

Seventy-five percent of the children received their insulin as a single morning dose (Table VI). Since most authorities feel that two daily injections are usually necessary to control labile juvenile diabetes, the prevailing practice seems to be at odds with this opinion. Review of the figures on a yearly basis does not indicate a trend towards multiple daily injections. Thus, a substantial majority of the children entering camp seem to be in programs at home that are felt to produce less than optimum treatment since they lack the flexibility provided by multiple injections or insulin mixtures, or both.

Hypoglycemic reactions severe enough to cause a child to turn himself in for observation at the medical shack are recorded as in Table VII. They seemed to be slightly more common in the girls, although not strikingly. The campers average about two mild reactions per week while at camp, indicative of the increased physical activity and attempts of the camp medical staff to improve control.

Records of the number of calories on admission were unfortunately not complete but are presented here as available (Table VIII). No bias is recognized of those available or not available. Generally a modification of calorie requirement upward was noted during the camping period. Weight gains and weight losses were approximately equal.

Regular urine testing was carried out on all campers. The result of this testing is recorded in Table IX and subdivided into the first and second weeks of the camping period. It is seen that increased contact with the child did not result in any improvement with results of the urine testing despite a generally energetic approach towards control of the diabetes. Further the constancy of testing results year in and year out seems remarkable.

These figures represent only a crude general identification of the experience of a group of diabetic children at Camp Firefly for the years 1964-1971. They do reflect the type of treatment of juvenile diabetes which is most prevalent in the geographical area which the camp serves. Fortunately there have been few major mishaps or illnesses during this period. Only on rare instances have children had to be removed from camp to a hospital for medical reasons. The only illness of epidemic proportion was external otitis in 1968 due to faulty filtering in the swimming pool.

TABLE VI
Administration of Insulin

Doses per Day	Girls	Boys
One	328	296
Two	116	97

TABLE VII
Hypoglycemic Reactions

	Girls								Boys							
Week	'64	'65	'66	'67	'68	'69	'70	'71	'64	'65	'66	'67	'68	'69	'70	'71
1		116	178					95		78	100					87
	194			245	153	154	261		180			163	149	87	151	
2		85	94					95		114	66					76

TABLE VIII
Calories at Admission

No. of calories	'64	'65	'66	'67	'68	'69	'70	'71	'64	'65	'66	'67	'68	'69	'70	'71
1200-1400	-	-	-	-	-	-	28	3	1	0	0	0	0	0	0	0
1500-2000	31	29	27	23	25	20	25	24	17	21	12	16	17	4	15	11
2100-2500	28	22	37	28	14	28	2	27	23	20	29	22	20	19	25	27
2600-3000	1	2	1	0	3	1	0	0	4	1	6	6	1	16	10	4
3100-4000	0	2	0	0	-	1	0	0	1	1	1	0	1	4	0	2
free	2	2	1	3	5	0	2	0	9	8	5	10	6	2	0	0

TABLE IX
Urine Test Results by Percentage of Tests Per Week Period

Girls

	'64		'65		'66		'67		'68		'69		'70		'71	
	*	x														
neg.	11	10	23	17	38	36	45	48	37	24	41	44	38	38	40	36
tr.	10	65	3	3	2	2	2	2	4	8	4	0	4	4	4	4
1	7	6	82	3	2	4	4	2	4	6	3	3	7	6	1	2
2	7	4	6	3	4	5	5	4	6	9	4	5	4	3	5	4
3	29	31	6	3	9	5	5	4	12	5	5	5	7	11	3	7
4+	36	44	60	71	45	48	39	40	37	48	42	43	38	38	47	41

Boys

	'64		'65		'66		'67		'68		'69		'70		'71	
	*	x														
neg.	19	17	35	38	42	39	52	39	43	40	41	40	42	44	40	42
tr.	6	4	2	2	3	3	2	3	4	3	4	6	7	6	7	7
1	4	3	4	4	2	2	2	3	3	2	3	3	1	1	5	5
2	5	3	6	3	3	3	5	6	5	5	4	4	3	4	4	5
3	31	37	6	7	5	3	7	9	5	4	3	4	7	7	6	7
4+	35	36	47	46	45	50	32	40	40	46	45	43	40	38	38	34

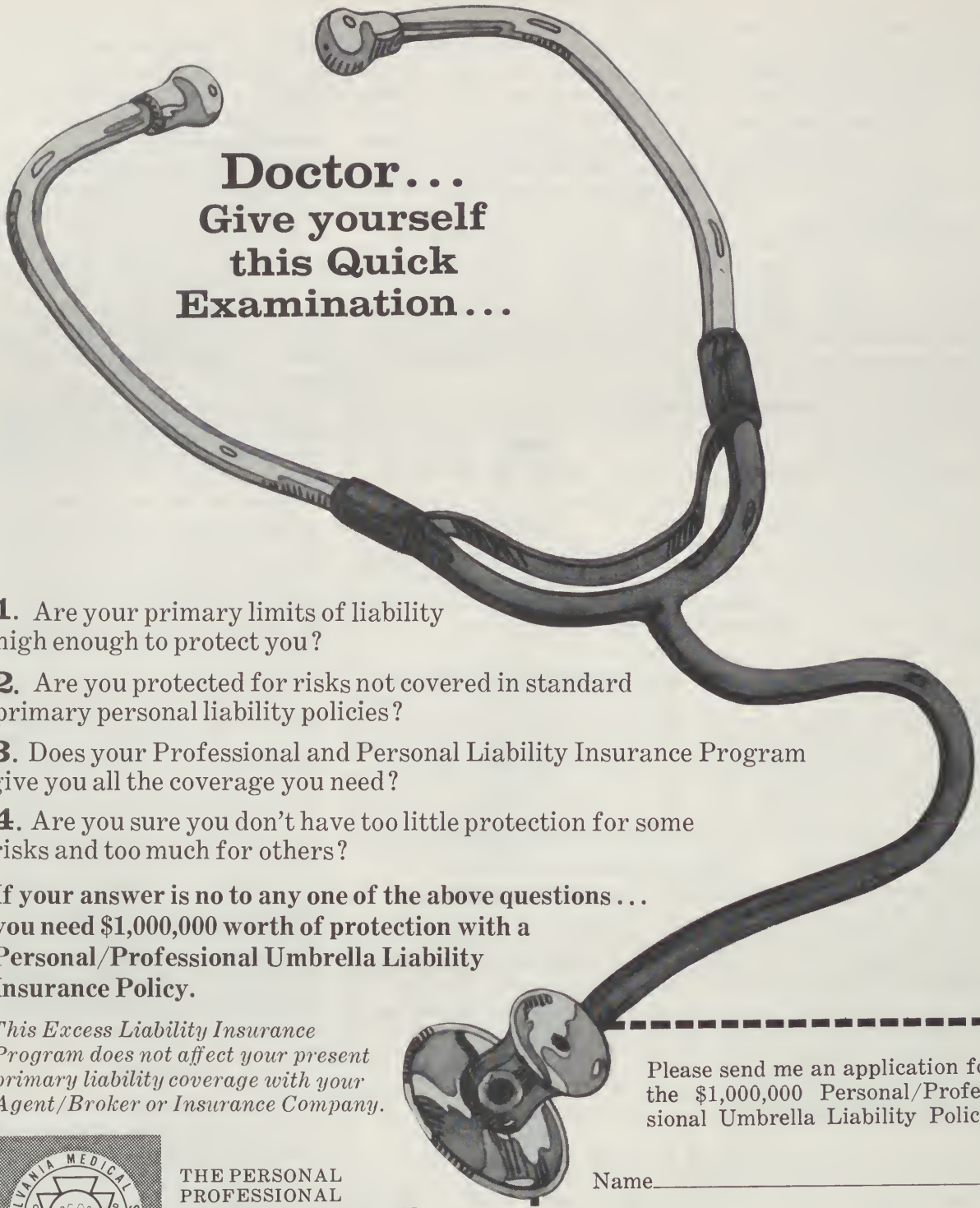
* First week period
x Second week period
Each test period represented approximately 1200 individual tests.

Conclusion

It is our enthusiastic recognition that camping represents an extremely valuable opportunity for the diabetic child. It is felt that multiple gains are to be derived from this experience. We actively solicit the support of other physicians and the referral of other children to the facility. □

REFERENCES

1. **White, P., and G.A. Graham.** The child with diabetes in *Joslin's Diabetes Mellitus*. A. Marble, P. White, R. Bradley, and L. Krall (Eds.) Lea & Febriger, Philadelphia, 1971.
2. **White, P.** Childhood Diabetes, Its Course and Influence on the 2nd, 3rd Generation. The Banting Memorial Lecture, 1960, Diabetes 9: 345, 1960.



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Pages 45-48 missing

obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Catherine L. Bacon,** Woods Hole, Massachusetts; Rush Medical College, Chicago, Illinois, 1927; age 74; died October 29, 1973. No further information is available.

• **Ruth M. Brenner,** Manheim; Woman's Medical College of Pennsylvania (Medical College of Pennsylvania), 1939; age 60; died October 8, 1973. She had been a practicing physician for thirty-two years. She was a past president of the Lancaster chapter of the Pennsylvania Affiliate of the American Heart Association. Survivors include her husband, two sisters, and her mother.

• **Cornelius F. Coll, Jr.,** McAdoo; Temple University School of Medicine, 1930; age 68; died November 8, 1973. He was a past president of the Hazleton Medical Society. He is survived by his wife, two daughters, a son, a sister, and a brother.

• **Robert D. Dripps, Jr.,** Philadelphia; University of Pennsylvania School of Medicine, 1936; age 62; died October 30, 1973. Dr. Dripps was vice president for health affairs at the University of Pennsylvania and former chairman of the department of anesthesiology at the university's school of medicine. He had been director of anesthesiology at the Hospital of the University of Pennsylvania, director of the American Board of Anesthesiology, senior civilian consultant in Anesthesiology to the Surgeon General, and a member of the National Advisory Research Resources Committee, U.S. Public Health Service. He was a member of the American College and the American Society of Anesthesiologists, the American Surgical Association, the Association of University Anesthetists, and the Philadelphia and Pennsylvania Societies of Anesthesiologists. His wife, a daughter, and a son survive him.

• **Benjamin A. Frye,** Sharpsville; University of Pittsburgh School of Medicine, 1904; age 92; died October 2, 1973. He is survived by a son.

• **Raymond J. Garvey,** Summit; Medical-Chirurgical College, Philadelphia, 1916; age 83; died October 26, 1973. He was a past president of the Lackawanna County Medical Society and a fellow of the American College of Surgeons. Survivors include his wife, a daughter, a son, and a brother.

• **William J. Hargreaves,** Johnstown; Jefferson Medical College, 1946; age 51; died October 20, 1973. He was chairman of the obstetrics and gynecology department at Memorial Hospital, Johnstown, and was a diplomate of the American Board of Obstetrics and Gynecology and a fellow of the American College of Obstetrics and Gynecology. He was also a past president of the Cambria County Medical Society. Survivors include his wife, two daughters, and a son.

• **Warren E. Hartman,** Bradford; University of Buffalo School of Medicine, 1931; age 65; died September 19, 1973. He is survived by his wife, two daughters, two sisters, a brother, and his stepmother.

• **Robert C. Johnson,** Uniontown; George Washington University School of Medicine, 1938; age 60; died October 23, 1973. He had practiced medicine in Uniontown for twenty-seven years. He is survived by his wife; two sons, one of whom is Thomas G. Johnson, M.D., Oakland, Maryland; a sister; and four stepchildren.

• **Frank H. Krusen,** Orleans, Mass.; Jefferson Medical College, 1921; age 75; died September 14, 1973. He founded the Temple University physical medicine department, directed the physical medicine department of the Mayo Clinic, and was the senior editor of the textbook "Handbook of Physical Medicine and Rehabilitation." He was named the American Medical Association's Gold Medal Doctor in 1968. He is survived by his wife and two daughters.

• **Margaret L. Littler,** Pittsburgh; State University of New York Upstate Medical Center, 1926; age 74; died October 7, 1973. Her specialty was psychiatry. Two sisters and a brother survive her.

• **Howard F. Moser,** Prospect Park; Jefferson Medical College, 1937; age 62; died September 21, 1973. No information is available regarding survivors.

• **Roland C. Moyer,** Shenandoah; Hahnemann Medical College and Hospital, 1930; age 68; died July 20, 1973. A son and a sister survive him.

• **Hugh A. O'Hare,** Corry; Stritch School of Medicine, Loyola University, Chicago, Illinois, 1929; age 70; died October 17, 1973. Survivors include his wife, four daughters, a son, and three sisters.

• **Michael G. O'Brien,** Scranton; Jefferson Medical College, 1925; age 70; died September 28, 1973. He was a past president of the Lackawanna County Medical Society and a member of the American Urological Association. Survivors include his wife; a daughter; five sons, one of whom is Thomas G. O'Brien, M.D., Santa Barbara, California; two sisters; and two brothers, one of whom is Joseph O'Brien, M.D., Scranton.

• **Arthur F. Seifer,** Phoenixville; Temple University School of Medicine, 1938; age 62; died November 14, 1973. He was head of the department of orthopaedic surgery at Phoenixville Hospital and former secretary of the Eastern Orthopaedic Association. Dr. Seifer was a fellow of the American College of Surgeons, the American College of Physicians, and the American Academy of Orthopaedic Surgery. His wife, two daughters, his mother, and a sister survive him.

• **George G. Shoemaker,** Pittsburgh; University of Michigan School of Medicine, 1914; age 82; died October 19, 1973. His wife, a daughter, and a son survive him.

• **Howard H. Stauffer,** Hershey; Temple University School of Medicine, 1939; age 60; died October 14, 1973. He was a member of the staff at the Milton S. Hershey Medical Center. After his retirement, he was employed by the Pennsylvania State Health Service. His wife and three sons, one of whom is Howard B. Stauffer, M.D., Oakland, California, survive him.

• **Ruth M. Rivard,** Merchantville, N.J.; Women's Medical College, 1909; age 86; died October 1, 1973. She is survived by a sister.

PENNSYLVANIA MEDICINE continuing education

This course listing is prepared by the Pennsylvania Medical Continuing Education Institute

CODE KEY
(indicates institution has Category One accreditation)*

*AAFP—Amer. Acad. of Family Phys. (Contact Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111)**
*ACC—Amer. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md.**
ACGP—Amer. Coll. of Gen. Practitioners in Osteo. Med. & Surg., Suite 1940, 111 W. Washington St., Chicago, Ill. 60602.
*ACP—Amer. Coll. of Phys., 4200 Pine St., Philadelphia 19104**
*AHA—Amer. Heart Assn., Pa. Affiliate, P.O. Box 2435, Harrisburg 17105**
*AMA—Amer. Med. Assn., 535 N. Dearborn St., Chicago, Ill. 60610**
*Chestnut Hill—Chestnut Hill Hosp., 8835 Germantown Ave., Philadelphia 19118**
*Clin. Path.—Pa. Assn. of Clin. Path., 1735 W. Main St., Norristown 19401**
*Coatesville VA—Coatesville Vet. Admin. Hosp., Coatesville 19320**
*Conemaugh—Conemaugh Valley Memorial Hosp., 1086 Franklin St., Johnstown 15905**
*Delaware Co.—Delaware Co. Mem. Hosp., Lansdowne Ave., Drexel Hill 19026**
*Dermatology—Pa. Acad. of Dermatology, 8220 Castor Ave., Philadelphia 19152 (c/o Charles H. Greenbaum, M.D.)**
*Einstein/North—Albert Einstein Med. Cntr./Northern Div., York & Tabor Rds., Phila. 19141**
*Elwyn—Elwyn Institute, 111 Elwyn Rd., Elwyn 19063**
*Geisinger—Geisinger Med. Cntr., Danville 17821**
*Hahnemann—Hahnemann Med. Coll., 230 N. Broad St., Philadelphia 19102**
*Harrisburg—Harrisburg Hosp., Harrisburg 17101**
M. S. Hershey—Pa. State Univ. Coll. of Med., M.S. Hershey Med. Cntr., Univ. Dr., Hershey 17033
*Institute— Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139**
*Jefferson—Jefferson Med. Coll., 1025 Walnut St., Philadelphia 19107**
*Lebanon VA—Lebanon Vet. Admin. Hosp., Lebanon 17042**
*Lehigh AHEC—Lehigh Valley Area Health Ed. Cntr., 17th & Chew Sts., Allentown 18102**
*MCP—Med. Coll. of Pa., 3300 Henry Ave., Philadelphia 19129**
*Mercy/Pgh.—Mercy Hosp., Pride & Locust Sts., Pittsburgh 15219**
*Norristown State—Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19141**
*Packer—Robert Packer Hosp., Sayre 18840**
*PAFP—Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111**
*Paoli—Paoli Mem. Hosp., Paoli 19301**
*PAO&O—Pa. Acad. of Oph. & Otol., 232 N. 5th St., Reading 19601**
PMS—Pa. Med. Society, 20 Erford Rd., Lemoyne 17043
*Radiology—Pa. Radiological Soc., 20 Erford Rd., Lemoyne 17043**
*Reading—Reading Hosp., 6th Ave. & Spruce St., Reading 19602**
*St. Margaret—St. Margaret Mem. Hosp., 265-46th St., Pittsburgh 15201**
*Temple—Temple Univ. Sch. of Med., 3400 N. Broad St., Philadelphia 19140**
*U. of Pa.—Univ. of Pa. Sch. of Med., 288 Med. Labs. Bldg., Philadelphia 19104**
*Pitt—Univ. of Pittsburgh Sch. of Med., 1022-H Scaife Hall, Pittsburgh 15213**
Roentgen Ray—Phila. Roentgen Ray Soc., Temple U. Health Sciences Cntr., Philadelphia 19140
*Warren State—Warren St. Hosp., Box 249, Warren 16365**
WP/RMP—Western Pa. RMP, 200 Meyran Ave., Pittsburgh 15213
*Washington—Washington Hosp., 155 Wilson Ave., Washington 15301**
*West Penn—Western Pa. Hosp., 4800 Friendship Ave., Pittsburgh 15224**
*York—York Hosp., George St. & Rathton Rd., York 17405**

Key to symbols:

( ) Indicates the PRA Category Number in which attendance at this program should be reported. You may report each hour of attendance.

Bold Face Type indicates an institution that has Category I accreditation. This name MUST APPEAR on your PRA APPLICATION to the AMA if you are to receive Category I credit.

In most cases each of the following continuing medical education activities has been granted AAFP and ACGP (Osteopathic) credit. Contact those offices for details.

PLEASE NOTE: The following listings are all new listings that have been received since the last publication of CONTINUING EDUCATION in the December 1973 edition of PENNSYLVANIA MEDICINE. Listings from the October and the December editions need to be integrated with the following to give a complete calendar.

CME PROGRAMS

Listed below are programs of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, the instructor, the frequency of sessions, fees, maximum registration, etc., contact the director at the address given in the course listing or in the CODE KEY box.

New Kensington; Dec. 5, 1973 - Nov. 6, 1974

(1) Continuing Education for Physicians; by Tri-County Branch Medical Society and **Pitt;** at Holiday Inn. Contact: Walter N. Zuck, M.D., Citizens Gen. Hosp., New Kensington 15068.

Norristown State; '73-'74 Academic Year

(1) Encounter with Bureaucracy: The Impact of Administration on Patients, Professionals, and Programs; Nov. 30 - Dec. 14, 1973. Contact: J. D. Pruitt, M.D., Dir. C.M.E., Norrist. St.

Pittsburgh: **Pitt;** '73-'74 Academic Year

(1) Anatomy Lecture and Dissection Course; Saturdays; at Eye & Ear Hosp.
(1) Anesthesia Conference; Thursdays
(1) Anesthesia /Critical Care Medicine Research Conf.; Mondays
(1) Autopsy Conference; Fridays; at Presby-Univ. Hosp.
(1) Cardiac Auscultation and Examination; Winter 1974
(1) Critical Care Medicine Clinical Grand Rounds: Tuesdays
(1) Dermatology Teaching Rounds; Mondays; at V.A. Hosp. (Oakland)
(1) Dermatology Teaching Rounds; Tuesdays; at Children's Hosp. and at Presby-Univ. Hosp.
(1) Histopath Conference (Dermatology); Thursdays
(1) Mycology Conference (Dermatology); Thursdays
(1) Gynecology Grand Rounds: Thursdays; at Magee-Womens Hosp.
(1) Hematology-Morphology Conferences; Tuesdays
(1) ICU Rounds; Tuesdays; at Children's Hosp. & V.A. Hosp. (Oakland)
(1) ICU Rounds; Fridays; at Presby-Univ. Hosp.
(1) Infectious Disease Rounds; Wednesdays
(1) Medical Conferences; Mondays, Tuesdays, Thursdays, Fridays; at Montefiore Hosp.
(1) Medical Grand Rounds; Fridays
(1) Medical Grand Rounds; Thursdays; at Montefiore Hosp.
(1) Medicine-Pathology Correlation Seminar; Saturdays; at Montefiore Hosp.
(1) Neurology Basic Science Seminar; Thursdays
(1) Neurology/Neurosurgery Conference; Wednesdays; at Children's Hosp.
(1) Neurology Teaching Conference; Saturdays
(1) Topics in Neurology; Mondays
(1) Neuropathology Conference; Wednesdays; at Children's Hosp.
(1) Neuroradiology Conference; Wednesdays; at Children's Hosp.
(1) Neurosurgery Staff Conference; Wednesdays; at Presby-Univ. Hosp.
(1) Obstetrics Grand Rounds; Tuesdays; at Magee-Womens Hosp.
(1) Grand Rounds in Ophthalmology; Thursdays; at Eye and Ear Hosp.
(1) Orthopedic Conference; Tuesdays; at St. Francis or Mercy Hosp.
(1) Orthopedic Fracture Conference; Wednesdays; at Children's Hosp.
(1) Orthopedic Grand Rounds; Wednesdays and Saturdays; at Children's Hosp.
(1) Adult Orthopedic Grand Rounds; Saturdays; at V.A. Hosp (Oakland)
(1) Orthopedic Pathology Basic Science Conference; Wednesdays; at Children's Hosp.
(1) Orthopedic Radiology Conference; Wednesdays; at Children's Hosp.
(1) Ophthalmic Pathology Conference; Thursdays; at Eye and Ear Hosp.
(1) Continuing Education in Otolaryngology; every other Monday
(1) Head and Neck Conference; Thursdays; at Eye and Ear Hosp.
(1) ENT Radiology Conference: Wednesdays; Eye and Ear Hosp.
(1) ENT Teaching Rounds; Fridays
(1) Otology Conference; Tuesdays; at Eye and Ear Hosp.
(1) Surgical Complications Conference (or Oculoplastic Conference); Fridays; at Eye and Ear Hosp.
(1) Pathology Conference; Mondays bi-weekly; at Presby.-Univ. Hosp.
(1) Pediatric Grand Rounds; Thursdays; at Children's Hosp.
(1) Physiology Colloquium; Mondays
(1) Plastic Surgery Grand Rounds; Tuesdays; at V.A. Hosp (Oakland)
(1) Plastic Surgery Teaching Conference; Fridays; at Children's Hosp.
(1) Psychiatric Educational Conference; Fridays; at Western Psychiatric Inst. & Clinic.
(1) Psychosomatic Conference; Thursdays; at Presby-Univ. Hosp.
(1) Case Centered Seminars in Psychotherapy for Psychiatrists; 10 sessions; to be arranged.

(1) Seminar for Leaders in Group Process of Consultation; Thursdays.
(1) Staff Case Conference; Mondays; at Staunton Clinic
(1) Radiology Interhospital Conference; Thursdays
(1) Radiology Teaching Conference; Thursdays
(1) Renal-Hypertension Conference; Tuesdays; at Presby-Univ. Hosp.
(1) Surgical Pathology Conference; Thursdays
(1) Surgical Grand Rounds; Saturdays
(1) Tumor Board; Thursdays; at Eye and Ear Hosp.
Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

Pittsburgh; **St. Margaret Mem. Hosp.**; '73-'74 Academic Year
(1) Community and Family Practice Seminars; Dec. 5, 1973 - July 31, 1974.
(1) Family Practice Journal Club; Dec. 14, 1973 - July 12, 1974.
(1) Medical Education Postgraduate Lectures; Dec. 13, 1973 - July 11, 1974.
(1) Ob-Gyn Conferences; Dec. 5, 1973 - July 31, 1974.
(1) Rheumatology for the Orthopedic Surgeon; Sept. 1, 1973 - Aug. 31, 1974; by **Pitt.**
(1) Rheumatology Grand Rounds; September 1, 1973 - August 31, 1974; by **Pitt.**
(1) Workshop in Rheumatology and Orthopedics; Sept. 1, 1973 - August 31, 1974; by **Pitt.**
Contact: Paul W. Dishart, MD., Dir. Med. Educ., St. Margaret

Sayre; **Robert Packer Hospital** - '73-'74 Academic Year
(1) Surgical Grand Rounds; Saturdays
(1) Tumor Conference; second & fourth Thurs.
(1) Clinical Pathological Conference; 3rd Wed. of Dec., Apr. & May
(1) Medical Grand Rounds; Fridays
Contact: Paul C. Royce, M.D., D.M.E., Packer

Sharon General Hospital - '73-'74 Academic Year
(1) Continuing Education for Physicians; Oct. 3, 1973 - May 1, 1974; by **Pitt.** Contact: Allen H. Holt, M.D., Dir., C.M.E., Sharon Gen. Hosp., 740 E. State St., Sharon 16147
(1) Continuing Education for Physicians; Nov. 16, 1973 - June 7, 1974; by **Pitt;** at Tumor Clinic. Contact: Thomas V. Murray, M.D., Dir., Tumor Clinic, Sharon Gen. Hosp., 740 E. State St., Sharon

COURSES

ADMINISTRATIVE MEDICINE

Apr. 5 & 6, 1974; Pittsburgh
(2) TAP (Trustee, Administrator, Physician) Institute; by PMS & Hosp. Assoc. of Pa. at Marriott Hotel. (Contact: PMS)

Apr. 19 & 20, 1974; Scranton
(2) TAP (Trustee, Administrator, Physician) Institute; by PMS & Hosp. Assoc. of Pa. (Contact: PMS)

BIOCHEMISTRY

Jan. 15 - Apr. 2, 1974; Pittsburgh
(1) Biochemical Mechanisms of Disease; at **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

FAMILY MEDICINE

Sept. 12, 1973 - Apr. 24, 1974; Pittsburgh
(1) Lunch Box Theater; and Seminars for the Practicing Physician; by **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

Jan. 2 - Mar. 27, 1974; Pittsburgh
(1) Seminars in Patient Centered Medicine; by **Pitt.**; at Staunton Clinic. Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

Apr. 24, 1974; Wilkes-Barre
(2) Practical Application of Nuclear Medicine in the Specialty of Family Practice; at Mercy Hosp. Contact: J. P. Brennan, M.D., D.M.E., Mercy Hosp., 196 Hanover St., Wilkes-Barre 18702

GENERAL MEDICINE

Jan. 31, 1974; Harrisburg
(1) Medical Care Evaluation Seminar; By **Pitt** and Hospital Utilization Project; at Host Inn. Contact: Hospital Utilization Project, 400 Penn Center Blvd., Pittsburgh 15235

Feb. 7, 1974; Pittsburgh
(1) Medical Care Evaluation Seminar; by **Pitt** and Hospital Utilization Project; at Sheraton Inn on the Mall. Contact: Hospital Utilization Project, 400 Penn Center Blvd., Pittsburgh 15235

OPHTHALMOLOGY and OTOLARYNGOLOGY

Apr. 29-30, 1974; Pittsburgh
(1) Orbital and Retro-Orbital Lesions; at **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

May 2-4, 1974; Pittsburgh
(1) Ophthalmic Micro-Surgery; at **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

SURGERY

Jan. - May, 1974; Pittsburgh
(1) Continuing Education in Surgery; at **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

Mar. 28-29, 1974; Pittsburgh
(1) Workshop in the Use of Staplers in Surgery; by **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

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Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

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Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

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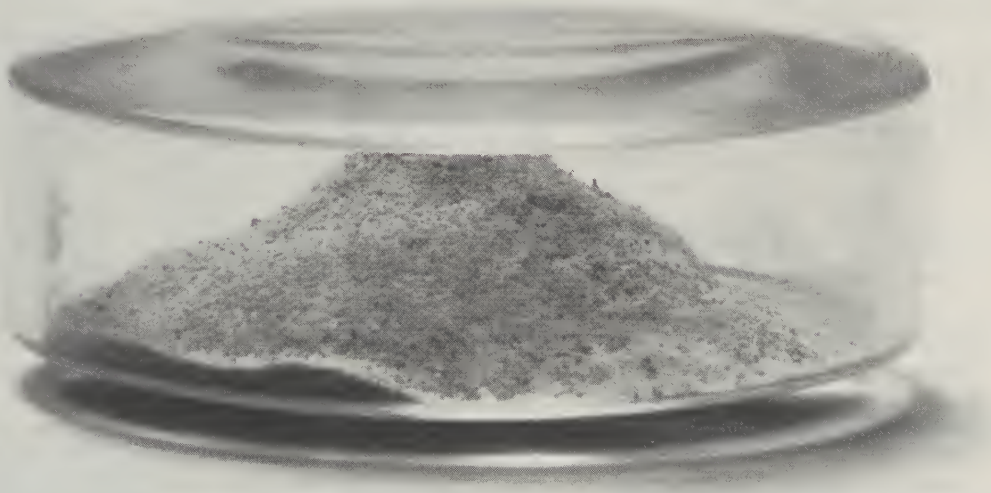

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natural thyroid therapy that leaves nothing to chance

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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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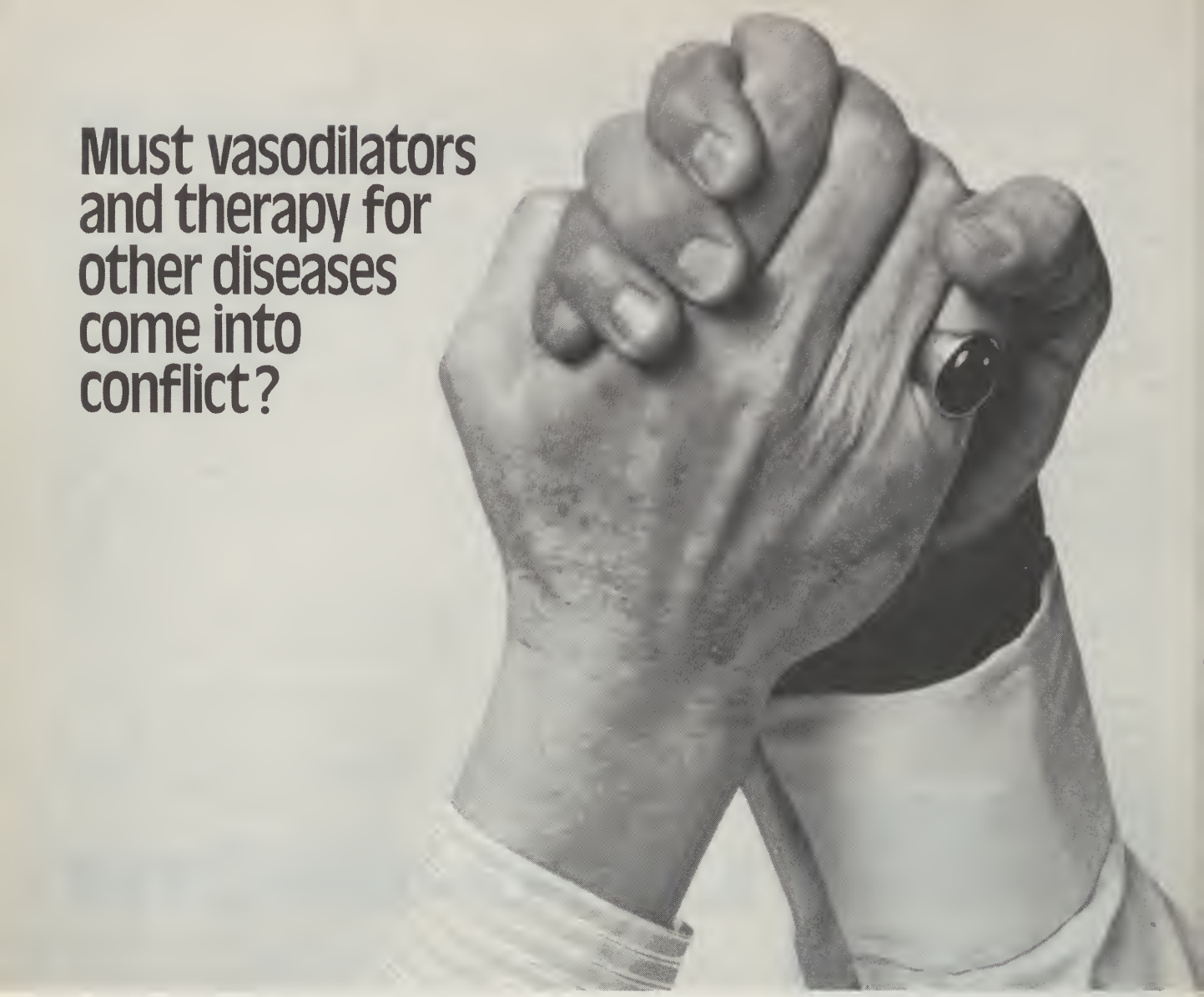

not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25:*134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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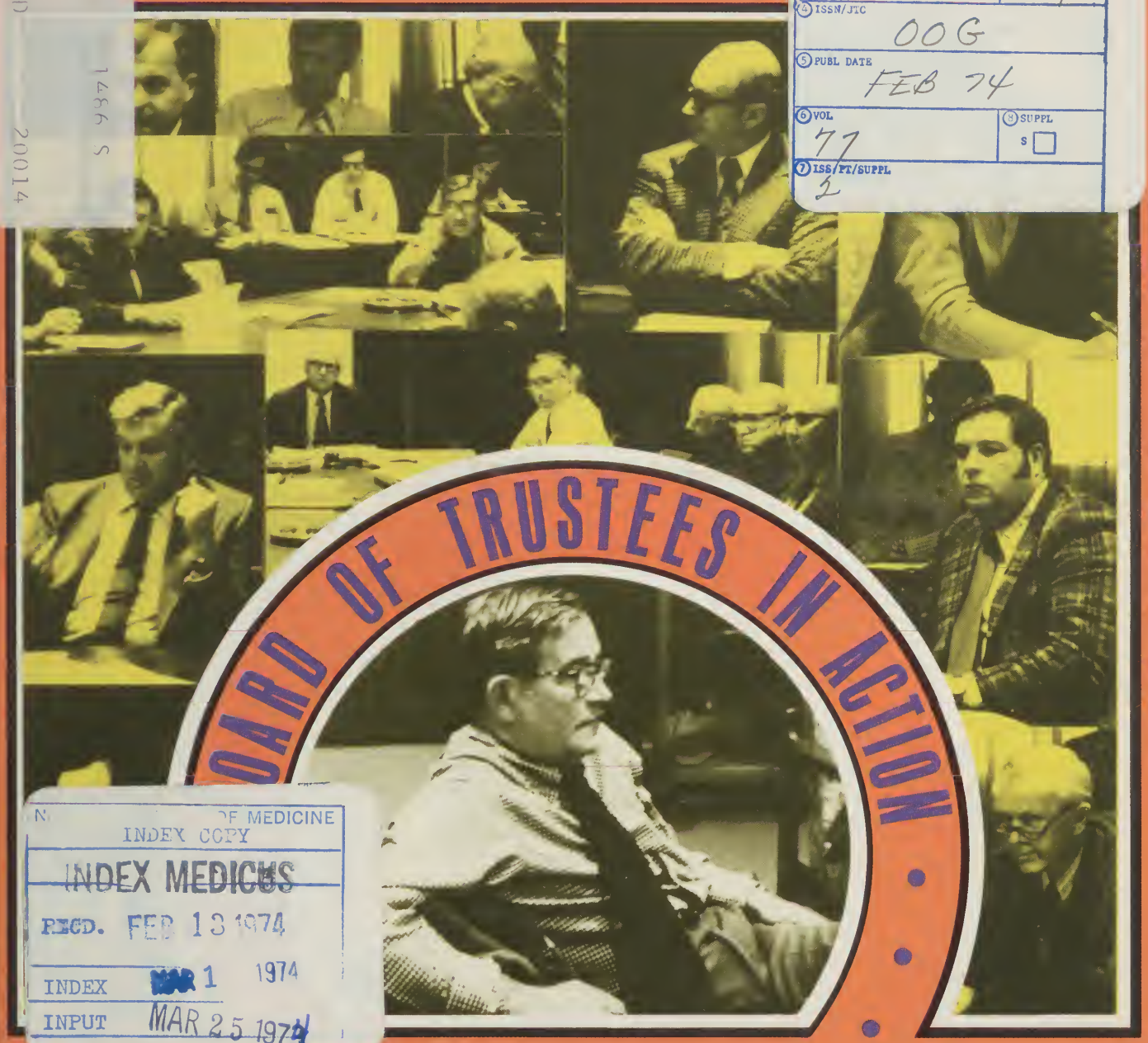

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February 1974

BOARD VOTES SUPPORT 'IN PRINCIPLE' OF H.B. 1550

The Board of Trustees in January voted to support in principle H.B. 1550, the"Pennsylvania Medical Education Planning Act." The bill would establish a Pennsylvania Medical Education Council and tie strings to medical school appropriations, so that 20 percent of funds would go to developing residency and continuing education programs in community hospitals and another 20 percent would be used to establish a student loan fund by the schools. The Board of Trustees called for the addition of a representative of the State Board of Medical Education and Licensure to the council, in addition to the Secretary of Health and the deans of four medical schools. Early hearings are expected on the bill and its companion bill, H.B. 1549, a proposed medical district act. Both bills have been referred to the House Committee on Education and are under study by various interested parties. Details will appear in future issues.

POST THAT SIGN!

The Cost of Living Council on January 16 filed with the Federal Register final Phase IV price regulations for the health industry. Generally the regulations limit increases for physicians' fees to 4 percent and hospital costs to 7.5 percent. The rules regarding physicians' fees were explained in the January issue of PENNSYLVANIA MEDICINE, on page 17, in an article by Leif C. Beck, Ll.B. One of the rules is that the physician must post a sign such as appeared in the January issue. If you have not posted the sign, write or call Society Headquarters, and one will be sent to you.

NEW BILL OFFERS PROTECTION FROM LIABILITY

Recently introduced H.B. 1729, the "Peer Review Protection Act," would provide immunity from liability for professionals serving on review committees and organizations and to those providing legitimate and pertinent information to such committees. The bill guarantees the confidentiality of all data received by review committees. The State Society caused the bill to be introduced and plans to work for its passage. It has been referred to the House Committee on Professional Licensure, where hearings are expected soon.

MEDICARE, MEDICAID REVIEW PROCEDURES PROPOSED

Proposed regulations requiring preadmission certification for nonemergency admissions for medicare and medicaid patients by a hospital utilization committee were published in the Federal Register in January. The regulations cover both hospital and skilled nursing facility admissions. Comments are being accepted by the Social Security Administration, which handles medicare, and HEW's Social and Rehabilitation Service, which administers the medicaid program. The Executive Committee of the Pennsylvania Medical Care Foundation's Board of Directors plans to file comments and has scheduled a meeting for this purpose. For details on the proposed regulations and their relationship to Professional Standards Review Organizations, see the article on page 15 of this issue.

COMMITTEE TO NOMINATE ASKS SUGGESTIONS Component county medical societies have received a request to make suggestions on the selection of nominees for the post of alternate delegate to the AMA. The request went from John L. Steigerwalt, M.D., chairman of the Committee to Nominate Delegates and Alternates to the AMA, who said, "This committee agrees that the House of Delegates should have some choice in the Delegation and the committee also believes this choice should come in the election of alternate delegates since this is the grooming area for advancement to the Delegation." March 15, 1974, is the deadline for suggestions, which should be accompanied by a curriculum vitae, including activities in the county medical society, the State Society, and the AMA.

LABORATORY EVALUATION RECOMMENDED The Board of Trustees in January voted to recommend to members operating laboratories in their offices to participate in a quality control program to determine operational proficiency. Both the College of American Pathologists and the American Society of Internal Medicine (ASIM) have such programs. The Proficiency Evaluation Program (PEP) of the College of American Pathologists offers analytical results, educational materials, a peer evaluation report, and a list of local consultants. For further information contact the College, 230 North Michigan Avenue, Chicago, Illinois, 60601. A similar evaluation, ASIM's Medical Laboratory Evaluation (MLE) is available. Further information is available from the Pennsylvania Society of Internal Medicine, Harrisburg.

HEALTH DEPARTMENT TO SURVEY STUDENTS The Board of Trustees has endorsed a proposed study of the Department of Health of medical students in the state to determine their preference for various specialties and practice location and the factors which influence the choice. The Board requested that survey results be made available to the Society.

LOANS, SCHOLARSHIPS EXCEED $200,000 The Educational and Scientific Trust of the State Society has announced that loans and scholarships to 202 medical and paramedical students has by far exceeded the $200,000 mark for 1973. This figure updates a report of trust activities in PENNSYLVANIA MEDICINE, November, 1973. The House of Delegates at its last Annual Session called on members to increase contributions or to begin to contribute to the trust to support the loan program and the loan forgiveness program initiated by the trust to encourage young physicians to practice in areas of need. Contributions are tax deductible.

BOARD ELECTS PaMPAC BOARD OF DIRECTORS The following physicians were elected to the Board of Directors of the Pennsylvania Medical Political Action Committee by the Society's Board in January: Drs. Paul S. Friedman, Philadelphia; R. William Alexander, Reading; Richard L. Huber, Scranton; David C. Scicchitano, Mount Carmel; R. Edward Steele, Harrisburg; William B. West, Huntingdon; Robert F. Beckley, Lock Haven; William D. Lamberton, Erie; Ralph M. Weaver, Butler; Robert J. Carroll, Pittsburgh; John B. Lovette, Johnstown; and Charles J. H. Kraft, Meshoppen.

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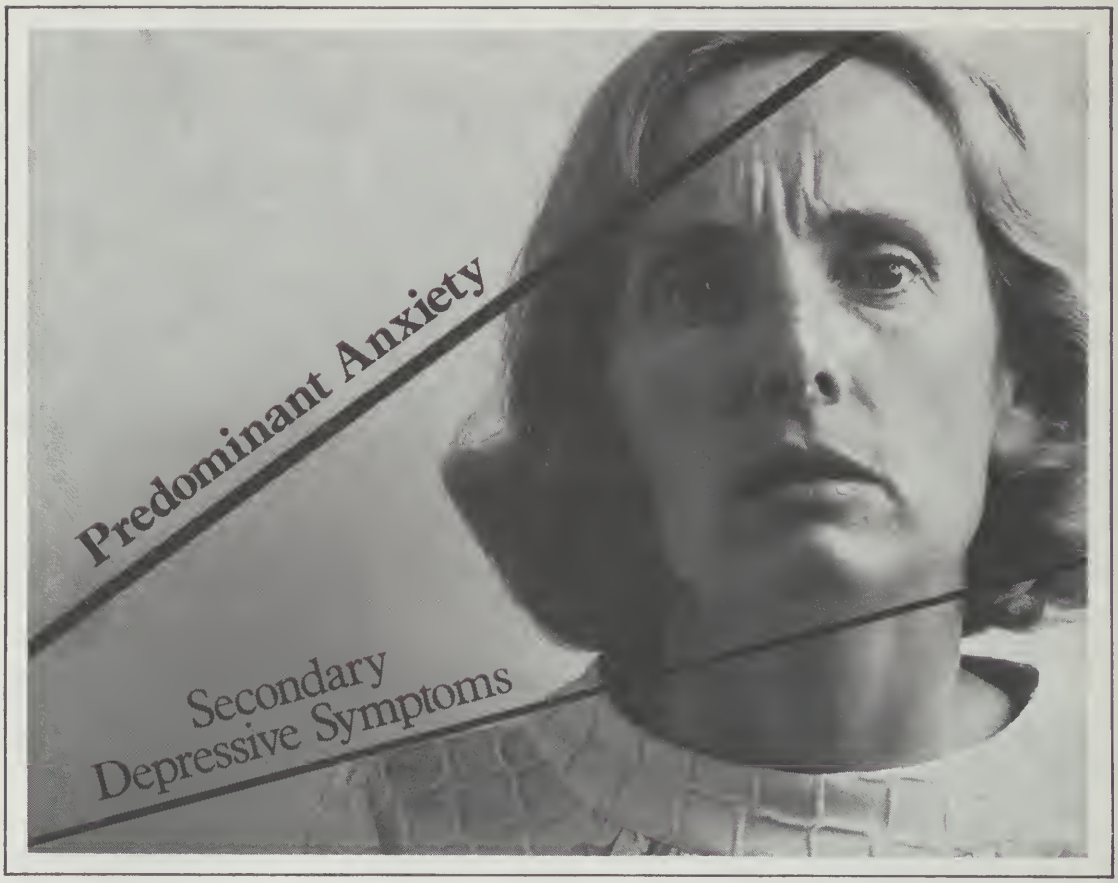

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex
to Valium® (diazepam)

Precautions: If combined with her psychotropics or anticonvulants, consider carefully pharmacology of agents employed; drugs ch as phenothiazines, narcotics, rbiturates, MAO inhibitors and her antidepressants may potente its action. Usual precautions dicated in patients severely deessed, or with latent depression, with suicidal tendencies. Observe ual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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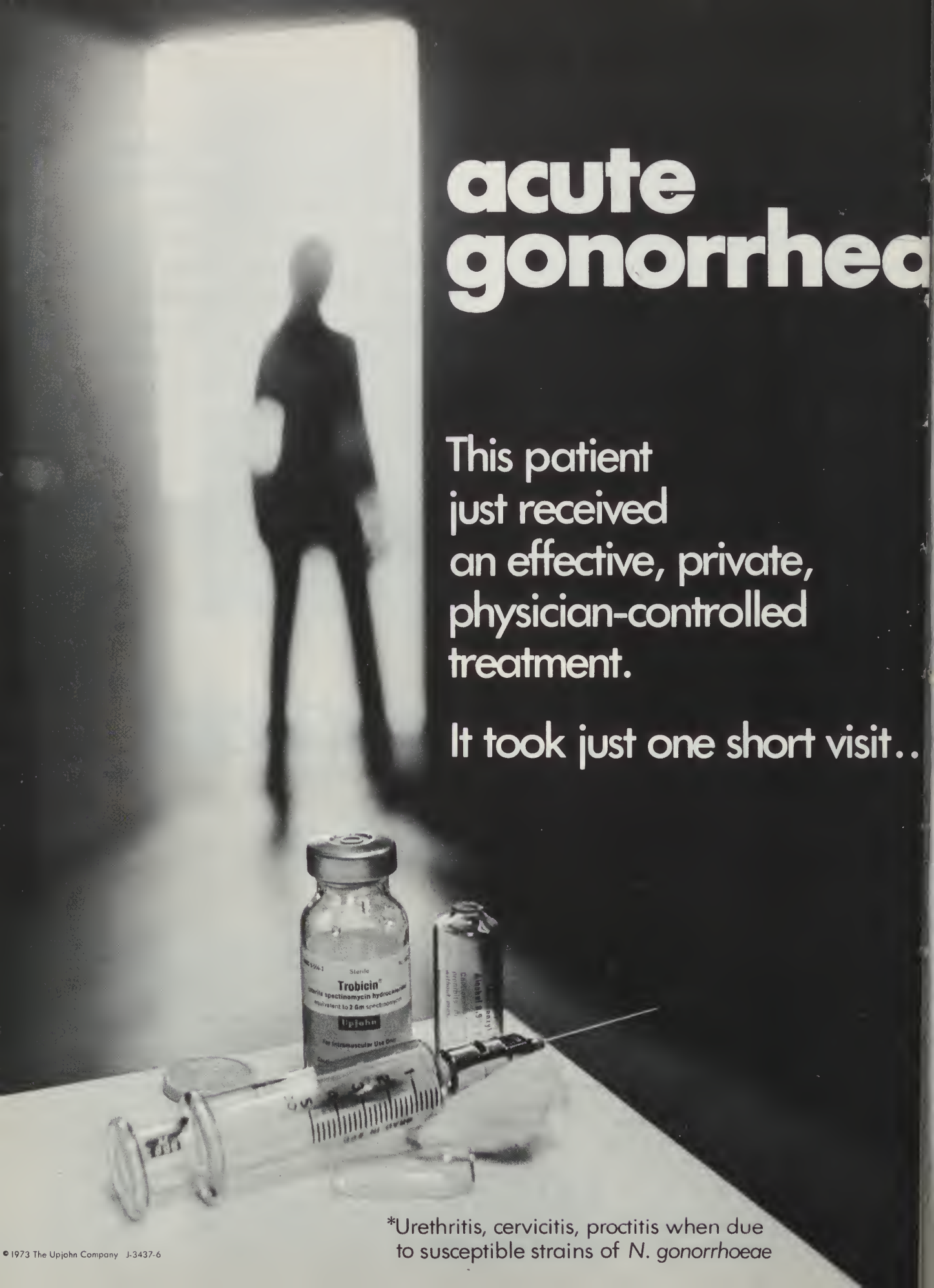
Valium® 2-mg, 5-mg, 10-mg tablets
(diazepam)



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin®

2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.
How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn

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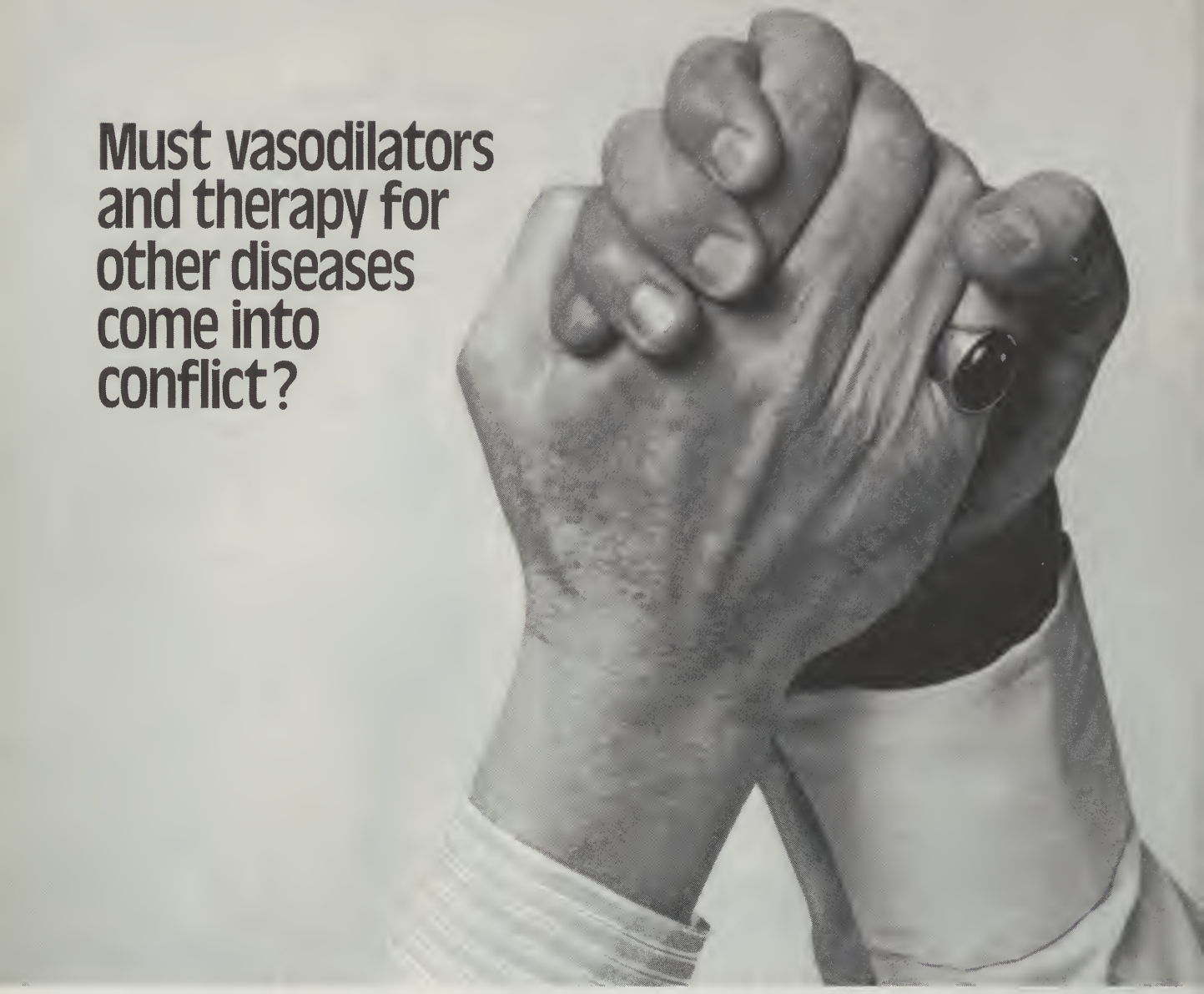
The Upjohn Company, Kalamazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes... yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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CATEGORY I CREDIT NOW AVAILABLE (in certain instances) FOR AUDIO-VISUAL MATERIALS

An important step has been taken in the crediting of audio-visual materials toward the Physician's Recognition Award. Responding to many inquiries from physicians, and recognizing the growing emphasis on the media, the AMA Advisory Committee on Continuing Medical Education adopted additional criteria under which the use of audio-visual materials can be accepted in Category 1. They are

A. Where only audio-visual materials are used by a physician on an individual basis, Category I credit may be claimed if all of the following are met (limit of 45 hours—an additional 22 hours may be claimed, if earned, in Category 5a)

1. The audio-visual materials are sponsored by an accredited continuing medical education institution (see list in PRA brochure);
2. The audio-visual materials comply with the definition of a "planned" program of continuing medical education (see PRA brochure);
3. The audio-visual materials contain supplements such as syllabi, study guides, references, or tests;
4. The audio-visual program is evaluated by the sponsoring organization;
5. The sponsoring organization must have a method of assuring physician participation.

B. Where audio-visual materials are used by groups of physicians or an individual physician as a part of a course (including a correspondence course) that meets the "planned" program criteria and has accredited sponsorship or cosponsorship, the time spent in the use of the audio-visual materials should be included as a part of the course in Category I. (no limit of credit hours)

C. Where audio-visual materials are used by physician groups, and this is the only educational method used, Category 1 credit may be claimed if

1. the audio-visual material is sponsored or cosponsored by an accredited sponsor;
2. the program complies with the definition of a "planned" program; and
3. there is an instructor present to supplement the program in terms of local continuing medical education needs and the educational objectives of the group. (no limit of credit hours)

HOW DO YOU KNOW IN WHICH CATEGORY TO REPORT YOUR OTHER CONTINUING MEDICAL EDUCATION ACTIVITIES?

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Board actions include letter on Blue Cross contract

As a result of one of the important actions taken at the January meeting of the Board of Trustees of the State Society, both the Delaware Valley Hospital Council and Blue Cross of Greater Philadelphia have been informed again of the Society's position that a "peer review process designed and directed by practicing physicians is appropriate for the effective and efficient operation of the health care system."

The restating of the position came as a result of the inclusion in a tentative letter of agreement between Blue Cross of Greater Philadelphia and the Delaware Valley Hospital Council of a section calling for pre-admission certification in all elective admissions and the establishment of length of stay on all admissions, to be accomplished no later than June 30, 1975.

The Board of Trustees, in a letter signed by Cyrus B. Slease, M.D., chairman, reiterated its position that such review mechanisms must be developed separately and should not be included in contracts with third party carriers.

Nominates to Corporate Board

The Board in further action nominated those eligible members of the Board of Trustees to fill eleven of the thirteen spots on the Blue Shield Corporate Board as a means of improving communications between the Society and Blue Shield.

Trustees nominated are the following, in the order of the district represented: Donald R. Cooper, M.D., Philadelphia; Leroy A. Gehris, M.D., Reading; Ralph K. Shields, M.D., Bethlehem; George A. Rowland, M.D., Millville; Raymond C. Grandon, M.D., Harrisburg; H. Thompson, Dale, M.D., State College; Kenneth L. Cooper, M.D., Williamsport; David J. Keck, M.D., Fairview; William J. Kelly, M.D., Pittsburgh; and Orlo J. McCoy, M.D., Bradford. Also nominated were Ralph C. Wilde, M.D., Society president; John H. Harris, Jr., M.D., Carlisle; and Milton B. Brandon, M.D., Williamsport. Dr. Slease already serves on the Blue Shield Corporate Board.

Other Board Actions

The Board of Trustees also: (1) determined that the chairman of the board of the Hospital Association of Pennsylvania (HAP) be invited to meetings of the Society's Board of Trustees and that Society President Wilde be the PMS representative at meetings of the HAP board; (2) approved the draft of the 1974 Officers' Conference agenda (see page 13); (3) agreed, on recommendation of Charles Laubach, M.D., chairman of the Regional Advisory Group of the Susquehanna Valley Regional Medical Program, that the Society become an institutional member of the National Association of Regional Medical Programs; (4) approved two nominations to the Interspecialty Committee—that of Leopold Loewenberg, M.D., Philadelphia, as delegate from District III, American College of Obstetrics and Gynecology; and Clair N. Shumway, M.D., Harrisburg, as alternate from the Pennsylvania Chapter, American Academy of Pediatrics.

Reports Received

The Board received reports in three areas of interest, two of them from Fred Speaker, legal counsel, and one from the Communications Division. Legal counsel reported that a Board action calling for the Society to enter into the case of Hoffman versus Misericordia Hospital, Philadelphia, as amicus curiae (in which an adverse decision could have resulted in absolute imposition of liability upon physicians when hepatitis resulted from blood transfusion) was no longer necessary because of the approval of Act No. 9, 1972, which limits liability in blood transfusion to a proof of negligence.

In the second legal matter, the 1973 House of Delegates ordered legal counsel to enter the case of Adler versus Montefiore Hospital Association of Western Pennsylvania as amicus curiae. This case, in which the physician was filing suit to use the cardiac catheterization laboratory of the hospital, was an appeal to the U.S. Supreme Court. Since the Supreme Court refused to reconsider the decision of the Pennsylvania Supreme Court which favored the position of the hospital, the case is closed.

The Communications Division presented to the Board results of its readership survey of the Society's *Executive Report*, showing that of those responding, 74.4 percent indicated they read it always; another 23.1 percent said they read it frequently; and 66.8 percent shared it with others.

The cover is a collage of informal photographs of the State Society's Board of Trustees as its members consider important items referred by the House of Delegates and matters of concern to medicine which require action between House sessions. Shown in the semi-circle is John B. Lovette, M.D., Johnstown surgeon, who was elected speaker of the House of Delegates at the 1973 session.

Library service changes

The Harrell Library at the Milton S. Hershey Medical Center has found it necessary to institute a modified fee-for-service for the PMS Library Service.

Pennsylvania Medical Society members will be entitled to five free cited requests (requests for a specific article) and one brief literature search per year without charge for photocopying. A brief literature search is a five-year search with three to five articles chosen which are obtained either through the computerized Medline service or through manual search. Charges beyond the one brief search permitted are $5.00 plus 20 cents per page for copies. Charges for additional cited requests beyond the five allowable are 20 cents per page (with a $2.00 minimum).

In addition, exhaustive searches are available. These use Medline exclusively and provide bibliography only, furnishing all available information on a subject. Charges for exhaustive searches are $15 per search plus 20c per page for copies.

Referrals made—action taken

Board acts on 1973 House of Delegates referrals

Action is being taken on all items referred by the 1973 House of Delegates to the Board of Trustees, with some items already settled.

As reported in the December issue of PENNSYLVANIA MEDICINE, the Board took action on certain referrals at a special meeting on November 14, 1973.

At that time the Board decided not to authorize a $10 membership assessment in 1974 to support the Pennsylvania Medical Care Foundation, but to use instead an amount up to $100,000 from the 1973 budget surplus for that purpose.

At that meeting the Board also approved the 1974 budgets of the Communications Division and the Council on Public Service, and authorized the council to expend up to $25,000 to recruit 2,000 members into a physicians' cooperative for mass purchasing of supplies. The council began action on this at its January meeting.

Plan C Action Deferred

In approving the concept of Blue Shield Plan C, a new fee schedule program, the House directed the Board to determine the appropriate income levels and fee schedule allowances, with members of the House of Delegates having the right of ratification by mail ballot. This matter was referred to the Council on Medical Service and legal counsel, but no further action on Plan C can be expected until the Blue Shield Corporation meeting in March.

PDUR Studied

The House sought an analysis of the Predischarge Utilization Review Program (PDUR) of the Department of Public Welfare (DPW) and directed the Board to obtain it. This item was referred to the Pennsylvania Medical Care Foundation, and the Foundation staff is working with DPW officials to get the information.

Referrals to Task Force

The Society's Convention Task Force received two referrals—reconsideration of the time and place of the 1976 meeting of the House of Delegates and a study of the advisability of holding all Annual Business Meetings after 1978 in the Harrisburg-Lancaster area. The task force is working on the latter referral, but acted immediately on the possibility of moving the 1976 meeting from the Bellevue-Stratford Hotel in Philadelphia to the Marriott Motor Hotel in that city. At its January meeting the Board of Trustees received the task force report that no suitable dates are available at the Marriott that year, and voted to keep the meeting at the Bellevue-Stratford, September 16-18, 1976.

Union Study Continues

Resolution 72-28 on physicians' unions was referred back to the Ad Hoc Committee on Physicians' Unions for further study, with the sponsor of the resolution to be invited to participate in the deliberations.

Resolutions Referred

Three resolutions were referred to the Council on Education and Science. Resolution 73-8, which calls for a standing committee of the council to give consultation and opinion on the therapeutic use of drugs, has been placed on the council's agenda for January 17.

Resolutions 73-10 and 73-13 also were referred to this council and are on the agenda for this meeting. These resolutions deal with the composition of hospital boards of trustees.

The Council on Education and Science already has begun to develop courses in medical economics and office management for physicians, as recommended in the president's address to the House of Delegates. Courses are being planned for various parts of the state in 1974.

Dr. Clare installed by Allegheny CMS

David W. Clare, M.D., Pittsburgh, was installed as president of the Allegheny County Medical Society at the society's annual dinner dance held on January 19 at the William Penn Hotel in Pittsburgh.

DR. CLARE

Dr. Clare is clinical associate professor of surgery at the University of Pittsburgh School of Medicine. He is a past president of the Allegheny County Unit and the Pennsylvania Division of the American Cancer Society and was formerly cancer coordinator at the University of Pittsburgh. He is a liaison fellow of the Commission on Cancer of the American College of Surgeons, a member of the American Cancer Health and Welfare Association's health strike force, and a member of the American Association for the Surgery of Trauma.

Other officers installed were Michael P. Levis, M.D., president elect; Lawrence D. Ellis, M.D., first vice president; Joseph V. Caliguiri, M.D., secretary; and Robert M. Laughlin, M.D., treasurer.

Western HMO opens

Western Pennsylvania's first Health Maintenance Organization (HMO) was opened February 1 at Centerville Clinic in Washington County. Blue Cross of Western Pennsylvania said it is one of several being planned there.

Membership in the Centerville Health Plan is expected to cost a family $46.25 a month to be paid through Blue Cross. Rate for an individual will be $15.30 a month.

Report to 'stockholders' feature

1974 Officers' Conference Program announced

A report to the "stockholders," financing medical education, physicians' assistants, the free-standing internship, voter research techniques, and medical staff law and bylaws are just some of the topics to be covered at the Society's 1974 Officers' Conference, April 24 and 25, at the Host Inn, Harrisburg.

R. William Alexander, M.D., of Reading, chairman of the Officers' Conference Committee, said those attending can expect "outstanding speakers, interesting discussions, buckets of pearls, and bags of gems."

Part of Wednesday afternoon's session will be a PaMPAC presentation, featuring Rex E. Kenyon, M.D., AMPAC Board Member, and Paul M. Newman, political analyst from California and president of his own research company noted for its scientific analysis of voter trends.

Banquet speaker this year is Mark Russell, resident comedian of the Shoreham Hotel, Washington, D.C. Russell's satire on the Washington scene has become a tradition at AMA meetings held in Washington. "Getting Russell is a real coup for the committee," Dr. Alexander said.

Other speakers confirmed to date include William F. Kellow, M.D., dean of Thomas Jefferson University School of Medicine; William A. Sodeman, M.D., chairman of the AMA Council on Medical Education; and C. H. William Ruhe, M.D., director of AMA's Division of Medical Education.

Presidents, presidents elect, secretaries, and executive secretaries are urged to respond early to conference invitations which were mailed in January so that their reservations will be assured. Societies with a membership exceeding 200 will be able to send six expense-paid delegates again this year. Specialty societies for the first time are entitled to send a delegate at the expense of the Pennsylvania Medical Society.

The conference opens at 2 p.m., Wednesday, April 24, and concludes Thursday at noon.

Members of the 1974 Officers' Conference Committee are John R. Boal, Jr., M.D., Beaver; William E. DeMuth, M.D., Hershey; John D. Mraz, M.D., Erie; George R. Fisher, M.D., Philadelphia; Orlo G. McCoy, M.D., Canton; Ralph C. Wilde, M.D., Society president, Pittsburgh; and Dr. Alexander.

Summer programs need assistance

Two separate medical student summer training programs will continue during the summer of 1974. Interested community hospitals, students, and physician-preceptors are urged to participate.

Last summer 125 students in fifty-nine Pennsylvania communities were trained, with the Medical Education—Community Orientation Program of the Student American Medical Association training fifty-two students and the Western Pennsylvania Health Preceptor Program of the University of Pittsburgh training seventy-three students.

Community hospitals are urged to submit student application forms; and physicians willing to act as preceptors, sharing office practice and hospital rounds experiences, are requested to contact Velma McMaster at PMS headquarters or Franciska G. Katona, director of the Eastern Pennsylvania MECO Program at the Temple University Student Center.

The eight-week training periods have met with considerable success in interesting students in primary care, acquainting them with community health facilities, and the programs are an aid in redistributing physician manpower.

The $75 a week stipend and arrangements for room and board required of the sponsoring hospital and/or hospital association is considered a non-taxable direct grant.

Blue Shield experiments under study

Two experimental Blue Shield projects of particular interest to Pennsylvania physicians have been under study for approximately a year by the Pennsylvania Blue Shield Research Department. The Pennsylvania Medical Society's Subcommittee to Advise Blue Shield and the Council on Medical Service continue to monitor these projects.

The Payment by Diagnosis Program would be based on a per case flat rate payment for in-hospital medical care with no limitation on length of stay. Compared to a straight fee-for-service with separate amounts allowed for each hospital visit or procedure, the advantages are expected to be two-fold: (1) An incentive would exist to reduce the length of stay and cost per case, and (2) claims procedures might be substantially simplified by reducing the amount of information needed for Blue Shield to process a claim. This program is an extension of a pilot study carried on by five physicians on the staff of the Wyoming Valley Hospital in Wilkes-Barre in 1972. The larger study is scheduled to begin this year for a two-year period, to include between seventy-five and a hundred doctors at eight to ten hospitals, and will cover approximately thirty diagnoses.

The second experimental project, the Primary Care Program, would be based on associations of physicians in groups to provide twenty-four-hour coverage and would cover all visits to participating physicians. It is expected to be ready for trial by the spring of 1974.

Rulings affect medicaid

Rulings by two courts, one state and one federal, have ordered that eligibility for medicaid be based on net rather than gross income. The ruling affects 20,000 to 30,000 Pennsylvanians by making them eligible for the medical assistance program.

Leonard Bachman, M.D., health adviser to Governor Milton J. Shapp, said this could mean additional state payments of $5.5 million to hospitals in the greater Philadelphia area, and could break the deadlock in negotiations between Blue Cross of Greater Philadelphia and the major hospitals of the area, since free care to the medically needy has been a major issue in those negotiations.

Argonaut insureds to receive 'correspondence course'

Almost 3,500 State Society members who are covered by the professional liability program sponsored by the Society will begin to receive next month a new and important service—a correspondence course in malpractice loss prevention and medical information designed to assist in providing safer and better patient care.

Initial announcement of the new program was made by Bruce Woolery, president of Argonaut Insurance Company of Menlo Park, California, underwriters of the PMS-sponsored program. Parker and Co. of Pennsylvania, Inc., Philadelphia, administrators of the program, will assist in distribution in Pennsylvania. The bulletin series, to be called Medical Alert Communications (MAC), will be distributed to Argonaut policyholders nationwide as a service to the public and the industry. Materials distributed will be prepared by a group of nationally recognized experts in the field of patient care and malpractice loss prevention under the direction of Eli P. Bernzweig, J.D., who joined Argonaut last fall as vice president after serving as director of the Secretary's Commission on Medical Malpractice of the Department of Health, Education, and Welfare.

"We feel our new service is a unique contribution by an insurance carrier interested in reducing all causes of medical injury," Woolery said. "We intend it to be an ongoing project providing not only medical-legal information, but also a variety of other kinds of data of practical value to physicians, nurses, hospital administrators, and others in the health care field."

Woolery said MAC is the first publication of its kind ever produced by the insurance industry and is the forerunner of other loss prevention educational materials to be developed by the company. "It reflects our belief that the insurance industry has an obligation to make health care safer for all Americans," he added.

Dr. Bernzweig wrote in a recent article that MAC is one company's immediate response to the challenge to the insurance industry to play a unique role in developing more significant loss prevention programs.

The MAC bulletin series will contain materials in all of the separate sections into which it will be divided and will be contained in a loose-leaf binder into which subsequent bulletins can be filed for reference. Not every mailing will contain materials in all sections. The sections cover medicine, nursing hospital administration, technology, medical jurisprudence, general comments, and MAC Alerts—high priority warnings of potential hazards in medical treatment, drugs, or instrumentation. The series will be indexed annually.

The editorial board includes Joel J. Nobel, M.D., Philadelphia, director of the Emergency Care Research Institute. Others on the board are physicians, nurses, attorneys, and hospital administrators representing all sections of the country.

Acupuncture courses available here

Physicians interested in acupuncture will have access to two symposia and an American Medical Association videotape.

An acupuncture symposium will be presented by the University of Pittsburgh Continuing Education in Medicine on September 16, 1974, at the university. Inquiries may be directed to William M. Cooper, M.D., Director of Continuing Education, School of Medicine, University of Pittsburgh, 1022H Scaife Hall, Pittsburgh, Pa. 15261.

Hahnemann Medical College and Hospital, is planning a symposium with limited registration April 1-3 which is primarily for medical school clinical investigators. For further information contact Teruo Matsumoto, M.D., Hahnemann Medical College and Hospital, Philadelphia.

The AMA videotape was prepared in 1972 and is available through the Medical Education Resource Center of the Pennsylvania Department of Education. It consists of an explanation and demonstration of acupuncture by participants in the Academy of Parapsychology and Medicine Symposium at Stanford University. The forty-two-minute program is in color and is reproduced on videotape or videocasette provided by an institution at no cost except the postage.

Chiropractors use it

A state investigator has revealed that at least fifteen to twenty chiropractors in the Pittsburgh area are practicing acupuncture, despite a policy statement from the State Board of Medical Education and Licensure that the ancient Asian treatment can be performed only by doctors of medicine and only in a clinical research setting, and despite orders from both national chiropractic associations that chiropractors should not use the treatment.

Reports indicate that the treatment is being performed by chiropractors in other parts of the state, although investigation is difficult because of lack of reporting and limited state staff to investigate illegal use of devices.

More on acupuncture

The second World Symposium on Acupuncture and Chinese medicine will be held on Friday, March 8 through Monday, March 11, 1974, in San Francisco, California.

The American Journal of Chinese Medicine in cooperation with the American Society of Chinese Medicine and the Acupuncture Research Institute is organizing the symposium.

For further information, contact the American Journal of Chinese Medicine, Office of the Editor, P.O. Box 55, Garden City, N.Y. 11530 or telephone (212) 270-1163.

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PENNSYLVANIA MEDICINE special report

Government continues efforts to control hospital admissions

ROBERT R. WEISER
Communications Division

The battle for control of the PSRO program in Washington continues to complicate that program's implementation, and the final outcome of the struggle remains unclear despite recent events.

The struggle for control remains an internal HEW problem. While the outcome of the fight isn't yet apparent, the reasons for it are much more obvious. The agency that finally gains control of PSRO will have a large say in any National Health Insurance Plan that Congress might pass. In the meantime the controlling agency would have a great deal of influence in the medicare and medicaid programs.

The battle involves three HEW agencies: the Health Administration, the Social Security Administration, and the Social and Rehabilitation Service. Since the Social Security Administration (SSA) administers medicare and the Social and Rehabilitation Service (SRS) handles the federal part of medicaid, it's obvious that these two should want a great deal of say in PSRO.

But the Bureau of Quality Assurance (BQA) in the Health Administration is also interested in PSRO. It's this agency that had appeared to be winning the fight.

The appointment of the acting director of the Office of Professional Standards Review (OPSR), Henry Simmons, M.D., to that position permanently seemed to indicate to many that the BQA was winning the PSRO power fight. As acting director, Dr. Simmons favored BQA when making staff appointments. In addition, he has left much of the day-to-day work of PSRO implementation to Dr. Michael Goran, acting director of the BQA. In turn, Dr. Goran has created three divisions within the BQA to handle PSRO implementation operations.

But Dr. Simmons' appointment hasn't dampened the interest of the Social Security Administration or the Social and Rehabilitation Service in PSRO. It appears neither is going to relinquish any power to BQA gracefully. Despite a great deal of memo passing at HEW, little headway in coordinating the efforts of the three in PSRO implementation is evident.

Now that area designations have been published and the PSRO implementation pace speeded, this rivalry promises to add additional confusion to the implementation process. This confusion will be most evident at the regional and local levels, where the Social Security Administration is much stronger in resources and manpower, which remain as of this writing uncommitted to PSRO implementation.

Within days of the announcement of Dr. Simmons as permanent Director of OPSR, HEW announced it had proposed new regulations for medicare and medicaid, expanding utilization review for both. The newly proposed regulations contain provision for pre-admission review, length of stay based on diagnosis, and concurrent review. It sounds very much like PSRO.

Under these proposed regulations Hospital Utilization Review Committees would be responsible for carrying out the review for medicare. Providing that the state does not substitute a "better arrangement," the review committees would provide the same function for medicaid.

It is not yet clear how these proposed medicare-medicaid regulations would effect PSRO implementation if they are put into effect. Under provisions of the Bennett Amendment, local PSROs must utilize the services of hospital review committees as long as these committees provide effective and timely review. The PSRO law further provides that until a local PSRO is established, review requirements under the medicare-medicaid regulations are to be followed. Thus, whether or not or if the Bennett Amendment is implemented, the review committees under these regulations would function much the same.

But will the review committees answer to the local PSROs first or to the Social Security Administration in medicare matters and the Social and Rehabilitation Service in medicaid matters? Future PSRO regulation will have to make this muddy picture a lot clearer. Since HEW has announced it expects to have fifty signed PSRO contracts by June, we can expect those regulations in the next two or three months.

Whether the newly proposed medicare and medicaid regulations will remain unchanged is another big question. HEW had previously tried to institute the changes without publishing regulations but was stopped by the AMA. That organization is on record as opposing pre-admission certification for either medicare or medicaid and has promised to fight any attempts to force this on physicians.

Meanwhile, the PSRO clock continues to tick. And at this time no one can guess whether HEW is creating a finely timed organization—or a bomb.

The Communications Division of the Pennsylvania Medical Society is monitoring developments regarding Professional Standards Review Organizations as well as other governmental efforts to put controls on hospital admissions by requiring precertification for elective admissions. From time to time special reports will be issued in this journal on news in this field.

practice management.

How to achieve effective controls over supplies

LEIF C. BECK, LL. B.
Bala Cynwyd

A number of small medical practices (comprising up to six doctors) have complained that they have no effective means of controlling their medical supplies. Their problems include lack of information as to available supplies and failure to reorder supplies when needed. Since nothing can be as frustrating to all concerned (the doctor, his staff and the patient) as failure to have an item on hand when it is needed, the following guidelines are suggested for use by any small medical office.

Single Responsibility.

One specific aide should be made responsible for the central supply area or cabinets (including refrigerator or freezer) and for all inventorying and reordering. In most offices, however, a second aide should be "cross-trained" to handle these responsibilities *only* during the primary person's vacations, illness, or termination. Unless one individual is so responsible and accountable to her employer, almost any supply system is likely to fail.

Replenishing of Rooms

All rooms requiring supplies (the examining rooms in medical offices) should be filled with each necessary supply to a prescribed total on a regularly scheduled basis. Usually they should be filled once a week and on a specific day each week—for instance, every Friday afternoon—unless an item requires replenishment more often. The reason for this rule is to assure a relatively steady depletion of the central supply, thus hopefully avoiding an unanticipated major drain on an item if several rooms should require total replenishment at the same time.

Responsibility for replenishing the individual rooms should normally be upon the persons responsible for those rooms (the nurses or assistants in a medical office).

If there are special circumstances, the central supply aide might be responsible for all replenishments (in which case she might even keep the central supply under lock and key), but this is not recommended unless necessary. Also, if there are drugs to be dispensed requiring legal accounting to regulatory agencies, the suggestions appearing under the subtitle, "Drug Records," should be considered.

Reordering Rules

The next step is to establish a specific minimum quantity of each item to be on hand when it must be reordered. This figure for each item should be based on both (1) the normal time lapse between when it is reordered and when it is received, and (2) the amount of the item normally used during that period of time. As a rough rule of thumb, I suggest reordering an item no later than when its quantity is down to twice what is usually needed to carry the practice through the reorder period.

Use of Supply Card

The central supply aide should keep an up-to-date "Supply Card" on each separate item. This form can be prepared inexpensively by any printer (preferably in a size such as 4" x 7") after an office lays it out to suit any special requirements. It should contain at least the following information:

(a) General name of item (as it is called in your office);

(b) Proper description, identification number, etc. for reordering purposes;

(c) Name, address, and telephone number of supplier and of the specific salesman or contact person;

(d) Minimum quantity to be on hand before reordering;

(e) Maximum quantity which may be on hand;

(f) In columns, the date and amount of each order, and date and amount received, and the unit price paid.

These supply cards should be kept in a small card file box, normally in alphabetical order, maintained only by the central supply aide. She may then use the cards for refer-

SAMPLE FORM OF SUPPLY CARD
(on 4" x 7" printed card)
SUPPLY CARD

Item: _____ Minimum on Hand_____
Ordering Description: _____
_____
Supplier: _____ Maximum on Hand_____
_____
_____

Date Order	Amt. Order	Date Rec'd.	Amt. Rec'd.	Unit Price	Date Order	Amt. Order	Date Rec'd.	Amt. Rec'd.	Unit Price

ence as she visually checks the central supply cabinet or area every few days, referring to the cards to determine whether an item which appears in low quantity should be reordered. When she does reorder, and when the item is thereafter received, she should mark the information onto the supply card. The card thus becomes a handy record of reorder times, price variations, and the like.

As an alternative to use of a file box, some practices place each card physically with the central supply of the item just in front of the quantity at which a reorder should be made. Under this system the card physically "tells" the aide to reorder as she is withdrawing supplies. I generally do not favor this system, however, out of concern that the supply card may too easily be misplaced.

Drug Records

If a practice dispenses drugs for which accurate records must be kept and periodically submitted to regulatory agencies, the rules suggested above should nevertheless be applied. In addition, however, the following special procedures may be useful:

(a) All such drug items must be solely within the central supply aide's control—perhaps in a separate locked compartment.

(b) Only that aide (or her relief person in case of absence) may hand out the drug items to other aides or to the doctor, and she must keep a running record of each item, quantity, recipient (or room) and date issued. This record can merely be on a yellow legal pad or note book.

(c) When such a drug item is given to a patient, it must be marked on the patient's charge slip for the attention of the bookkeeper.

(d) The bookkeeper should in turn make a separate list which should be periodically checked against the supply aide's record of issuances before submitting a report to the regulatory agency involved. Any deviations between the two lists would indicate a problem to be investigated by the bookkeeper and supply aide, with the doctor's involvement if necessary.

Mr. Beck is President of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

FLEX used for first time by Pennsylvania State Board

Pennsylvania has become the forty-sixth state to use FLEX to test physicians wishing to be licensed in the Commonwealth. Until the first FLEX was administered December 4 at the Host Inn, Harrisburg, the State Board of Medical Education and Licensure had used its own customized test twice yearly.

FLEX, an acronym for "Federation Licensure Examination," in use for five years now, is a cooperative achievement of the Federation of State Licensing Boards, and is based on current and pretested questions from the pool of the National Board of Medical Examiners (NBME). The federation hopes to have FLEX in use in all fifty states in the near future.

Since the goal is to have a test of middle-range difficulty, FLEX committees eliminate overly easy or unusually difficult questions. Committees hold critical reviews twice a year and confer with NBME representatives to improve and stabilize the examination.

Lasting three days, FLEX uses objective, multiple-choice, machine-graded questions, which on the first day emphasize basic sciences; the second day, clinical sciences; and the third day, clinical competence. Examinees range from new medical school graduates to people out of school for many years.

Although the examination is given twice a year on the same dates throughout the nation, it is administered by each state board. Those wishing to take the test can obtain applications from any state board which honors FLEX.

The next FLEX is scheduled for June 11, 12, and 13. The deadline for filing an application with the State Board of Medical Education and Licensure is March 11, 1974. The cost is $100, and applications are available from Mrs. Alva Cockley, Secretary, State Board of Medical Education and Licensure, 279 Boas St., Harrisburg, Pa. 17102.

Goals of FLEX are: (1) To provide high quality, uniform, and valid examination so that state boards can better evaluate clinical competence; (2) To update licensure examination in relation to modern medical education; (3) To establish uniform levels of examination among the states; (4) To create a basis for interstate endorsement; and (5) To provide a basis to help in managing the foreign medical school graduate problem.

The immediate effect of the switch to FLEX in Pennsylvania was to cut the number of examinees by nearly two-thirds. More than 1,100 physicians took the May 1973 Pennsylvania licensing examination. Only 428 sat for the December FLEX in Harrisburg. Foreign medical school graduates again were in the overwhelming majority.

What you'll hear discussed at the
1974 Officers' Conference

Report to the "Stockholders"
Unraveling the Distribution Knot
Whither PSRO
PaMPAC and the Amazing Vote Research Machine
Medical Staff Law—Myth, Rumor, and Fact
Keeping Up. . .and Up. . .and Up—Continuing Education

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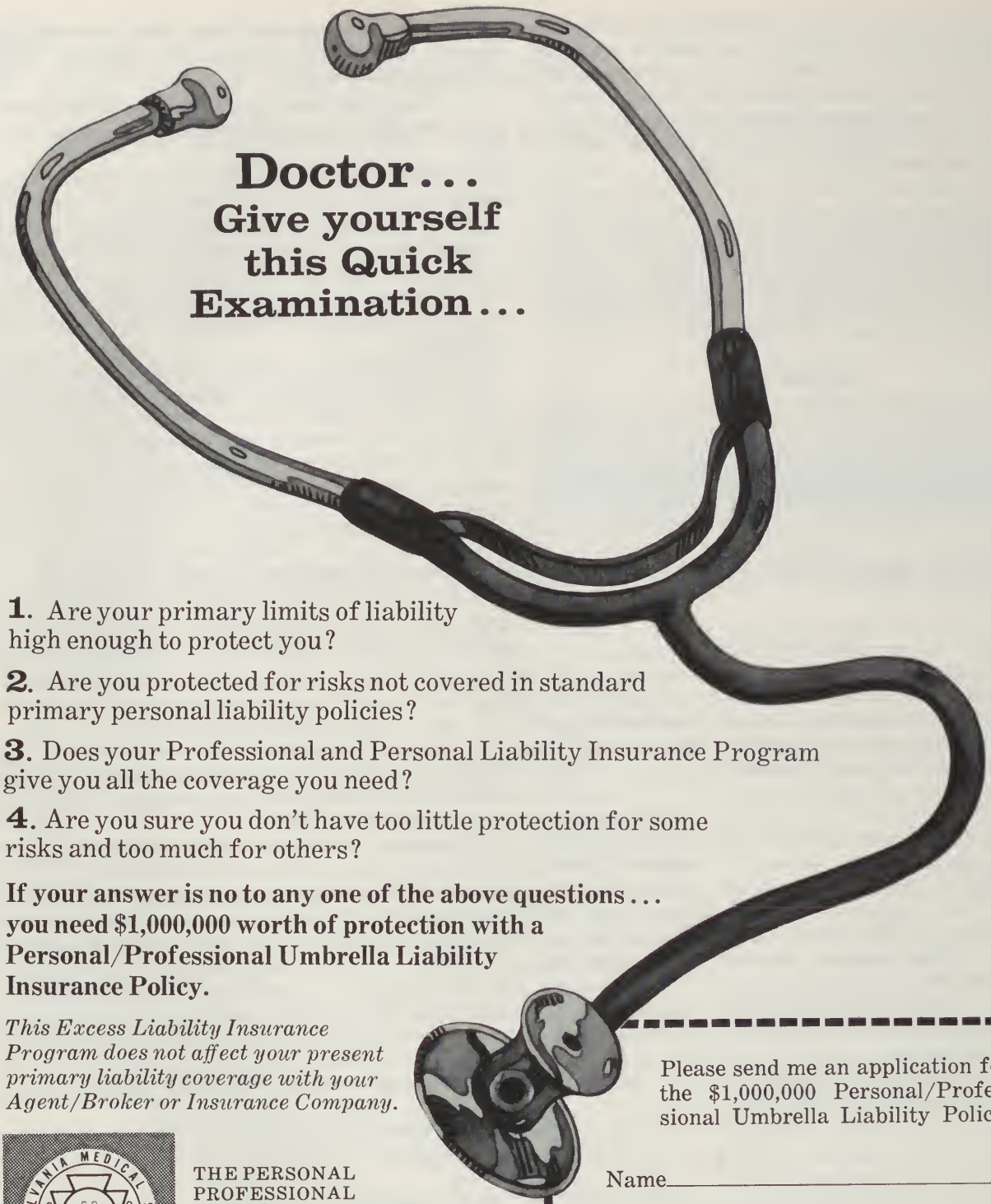

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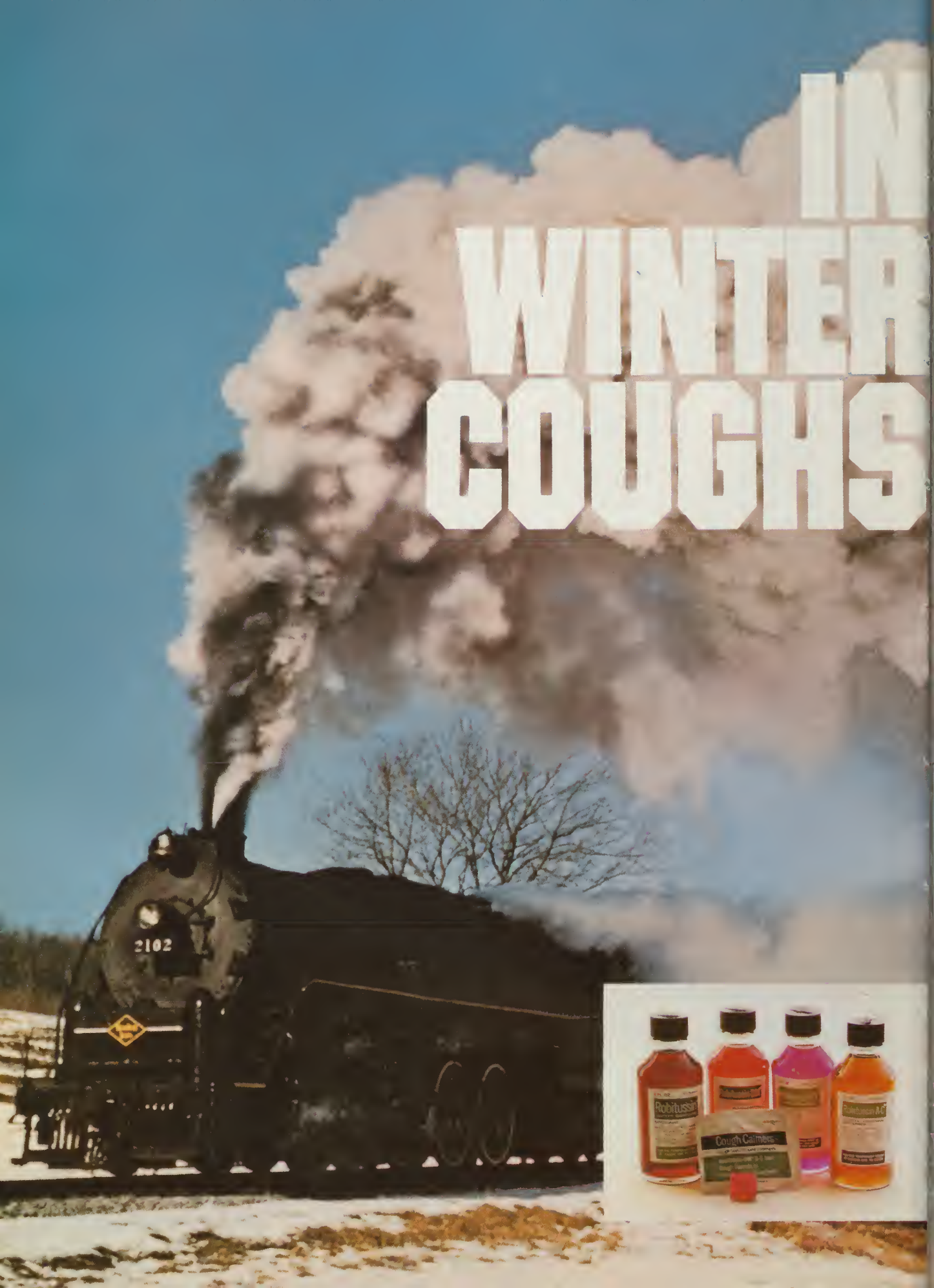

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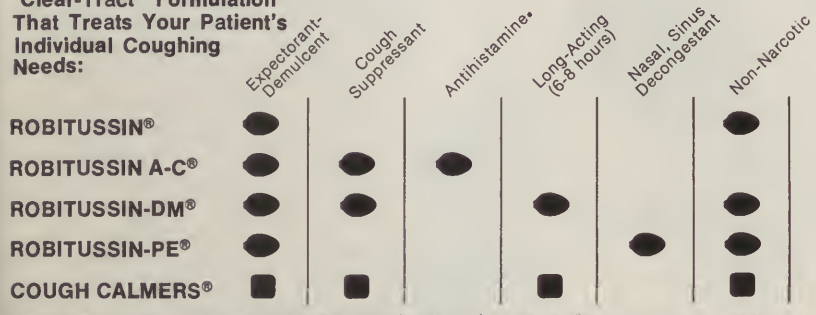

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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M.D.s in the news

ISRAEL ZWERLING, M.D., has been named professor and chairman of the department of mental health sciences at Hahnemann Medical College and Hospital, Philadelphia. He was previously director of the Bronx State Hospital and professor of psychiatry at Albert Einstein College of Medicine, New York. He is a fellow of the American Psychiatric Association, the American Association on Mental Deficiency, and the New York Academy of Medicine.

DR. ZWERLING

DR. WOLFSON

The award of honor from the American Academy of Ophthalmology and Otolaryngology was presented to ROBERT J. WOLFSON, M.D., Bala Cynwyd, at the recent annual convention in Dallas, Texas. He is professor of otolaryngology and head of the section at the Medical College of Pennsylvania. Dr. Wolfson is a diplomate of the American Board of Otolaryngology and a fellow of the American College of Surgeons.

Two members of the faculty at Pennsylvania State University School of Medicine, Milton S. Hershey Medical Center, have been named to national posts of medical specialty organizations. HARRY PRYSTOWSKY, M.D., provost of the medical center and dean of the medical college, and WILLIAM E. DeMUTH, M.D., professor of surgery, will serve on the board of governors of the American College of Surgeons.

GEORGE B. FARIES, JR., M.D., and DONALD L. ADAMS, M.D., Harrisburg Hospital staff members, have recently received board certification in their specialties. Dr. Faries, assistant surgeon in outpatient services, has been certified by the American Board of Surgery. Dr. Adams, assistant in obstetrics and gynecology, has been certified by the American Board of Obstetrics and Gynecology.

BERNARD A. KIRSHBAUM, M.D., associate clinical professor of medicine in dermatology at Medical College of Pennsylvania, and JOHN H. DOSSETT, M.D., assistant professor of pediatrics at the Pennsylvania State University School of Medicine, Milton S. Hershey Medical Center, were guest speakers at a recent symposium on medical care cosponsored by the Lackawanna County Medical Society and the Lackawanna chapter of the American Academy of Family Practice. Dr. Kirshbaum discussed the dermatological manifestations of vascular and neurological diseases and problems of VD. Dr. Dossett spoke on pediatric emergencies and genito-urinary diseases in children.

New chairman of the department of pathology at the University of Pennsylvania School of Medicine is DAVID T. ROWLANDS, M.D., an immunobiologist who has been professor of pathology at the school and researcher in cancer and organ transplantation. He is currently chairman of the medical school's curriculum committee and chairman of both the personnel committee and medical faculty senate. He is a past president of the Immunology Club of Philadelphia.

A. THOMAS ANDREWS, M.D., has been named director of education for the department of medicine at Harrisburg Hospital. He is certified by the American Board of Internal Medicine.

JOHN C. GAISFORD, M.D., chief of the division of surgery at the Western Pennsylvania Hospital, Pittsburgh, has been elected vice chairman of the American Board of Plastic Surgery. He was also named second vice president elect of the American College of Surgeons.

JOSEPH J. RUPP, M.D., and O. DHODANAND KOWLESSAR, M.D., were guest speakers at a program on malabsorption syndrome and gastrointestinal hormones conducted by Jefferson Medical College, Philadelphia, in Franklin recently. The program was sponsored by the Franklin Hospital.

D. C. PEWTERBAUGH, M.D., York pediatrician, was honored at a dinner recently when his portrait was presented in appreciation for his many years of service in the field of child growth and development.

HUGH R. GILMORE, JR., M.D., chief of the cancer control section of the division of communicable diseases of the Pennsylvania Department of Health, has been elected secretary of the Pennsylvania Cancer Coordinating Committee.

AHSEN T. OZARDA, M.D., formerly associate professor of radiology at the University of Missouri Medical Center, has been named radiation oncologist for the new supervoltage radiation therapy unit scheduled to open early in 1974 at Westmoreland Hospital in Greensburg.

CYRIL H. WECHT, M.D., clinical associate professor of pathology at the University of Pittsburgh Schools of Medicine and Dentistry, Pittsburgh, was elected National Correspondent of America by the International Academy of Legal Medicine and Social Medicine in Rome, Italy, recently.

ALBERT P. SELTZER, M.D., chief of the department of plastic and reconstructive surgery at St. Luke's and Children's Medical Center, Philadelphia, recently lectured on plastic surgery of the nose and face lift operation in Bangkok, Thailand, and Hong Kong.

A plaque in honor of volunteer service in Israel during the recent war is presented to S. Osher Pais, M.D., Rydal (right). Milton M. Perloff, M.D. (left), president of the medical staff of Albert Einstein Medical Center Northern Division made the presentation to the radiologist.

PENNSYLVANIA MEDICINE

M.D.s in the news

HENRY A. ARKLESS, M.D., Bala Cynwyd, has been appointed clinical assistant professor of medicine at Jefferson Medical College of Thomas Jefferson University and affiliate in cardiology at Albert Einstein Medical Center, Daroff Division. He is a fellow of the American College of Physicians.

ROBERT J. DEMUTH, M.D., Erie plastic surgeon, presented a seminar at Meadville City Hospital recently. It was part of a series sponsored by the Crawford County Medical Society, the Pennsylvania Medical Society, and Gannon College. He spoke on the care of minor hand injuries.

WIDAD BAZZOUI, M.D., former associate professor of psychiatry at the University of Missouri, has moved to McKean County to become medical director of the drug and alcohol program of the Cameron-Elk-McKean-Potter Mental Health, Mental Retardation Department.

Harry Null, M.D., a physician at West Penn Hospital, Pittsburgh, donated a pint of blood on his birthday recently, launching a new blood donation drive which "is the hottest and best thing to come down the pike," according to Ned Maxwell, M.D., director of the Central Blood Bank of Pittsburgh.

Physicians' birthday pledge cards have been sent to all 2,000 members of the Allegheny County Medical Society asking physicians to pledge a pint of blood on their birthdays. During the first week, a hundred pledge cards were signed. A special birthday card and wall placard will be sent to each participant.

Paid donors, who have a record of three cases of hepatitis per 1,000 donors, were eliminated by the blood bank in October 1972. The incidence of hepatitis in volunteer donors has been only eight in 10,000. In addition, the elimination of payments to donors has saved $150,000 per year.

It is hoped that the public will be as responsive to the birthday pledge campaign as physicians have been.

New Officers

Mercer County Medical Society
Anderson Donan, M.D., Grove City, president
Vincent Ricciutti, M.D., Sharon, president elect
William McWhirter, M.D., Greenville, vice president
Robert Allen, M.D., Sharon, secretary-treasurer

Lehigh County Medical Society
Raymond P. Seckinger, M.D., Allentown, president
Leon N. Branton, M.D., Allentown, president elect
Morton I. Silverman, M.D., Allentown, vice president
Howard L. Carbaugh, M.D., Allentown, secretary

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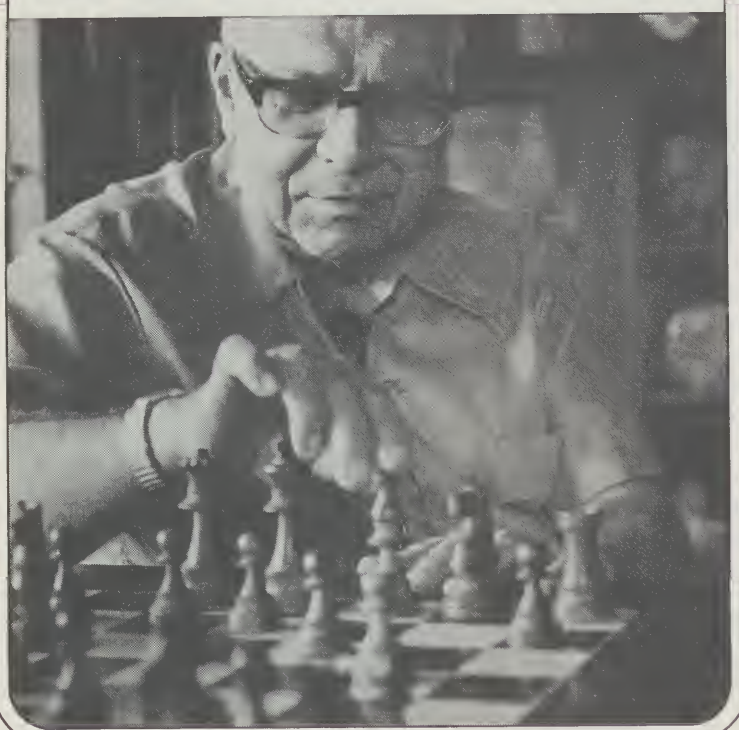

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CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

PENNSYLVANIA MEDICINE editorials

Advise parents—protection prevents accidents

Accidental injury represents a major threat to the health and safety of our population. In some studies, accidents have outranked disease as a leading cause of mortality and disability. In Pennsylvania in 1971, accidents were the third leading cause of death in children under the age of five years, preceded by diseases of early infancy and congenital anomalies.

Accidents among children may be divided according to age and type of hazard or injury most prevalent at that stage of development. For example, the greatest number of injuries in the one to two year age group seems to be due to impact injuries or falls. A twelve to eighteen month old child is beginning to develop motor skills and the tendency to run into household items, such as furniture, is greater than at a later age when these skills are more highly developed.

Poisoning represents the next major developmental hazard. Drugs have been named as a major source of intoxication in the two to four year age group. There are, however, other more readily available items in a normal household which may cause accidental poisoning, such as solvents or cleaners. The home, a child's principle environment, provides more sources of potential poisoning than any other area. A recent paper in a pediatric journal reported on the hazards of lead poisoning from colored printing ink to children who supplement their diets with magazines. Accidental poisoning, in most cases, has *not* been the result of poor or unsafe packaging. Rather, the causative agent was in the proper container but in an improper or unusual location. This is not to say that all products that are dangerous or injurious should not be labeled as such or that improvements can not be made on containers. Child-proof caps are a recent innovation in the packaging of drugs and other caustic household items. Many cases of accidental intoxication may be avoided simply by replacing the cap securely and putting the product in its proper storage area.

Burns or thermal injuries are another hazard to the preschool child. Most burn incidents are caused by normal everyday items. A major home burn injury is scalding by hot liquids. The FDA controls toys and other children's products which present electrical or thermal hazards. Flammable fabrics are controlled to some extent in that, since July 1973, children's sleepwear up to size 6X must be flameproofed.

The best method of prevention of accidental injury to children of the preschool age is protection. As the child grows and develops, education will replace the need for protection. Accidents will never be completely eliminated, but watchfulness and the old adage "A place for everything and everything in its place" could reduce childhood injury and death.

David A. Smith, M.D.
Medical Editor

PENNSYLVANIA MEDICINE correspondence

Question on Cromolyn

To the editor:

I refer to a letter to the editor from Dr. Louis Tuft appearing in the December '73 issue.

While I am in complete agreement with the contents of Dr. Tuft's letter, one of his statements has little or no substantiation. This relates to the reference that pneumonitis will result from the use of Cromolyn Sodium. After reviewing all of the literature, to my knowledge there has been just one isolated case, reported from Israel. This pertained to a hyper-sensitivity pneumonitis following the use of this drug in a middle aged female patient.

Harold I. Lecks, M.D.
Bala Cynwyd

Kudos to Leif Beck

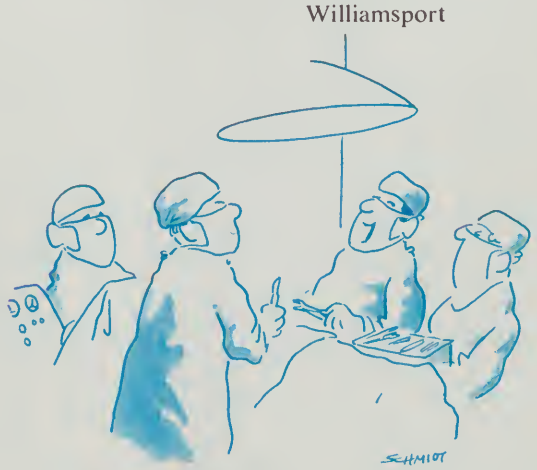
Leif C. Beck, L.L.B.
Management Consulting for Professionals, Inc.
Bala-Cynwyd, Pa. 19004

Dear Mr. Beck,

I would like to express my appreciation for the fascinating articles that you are writing in Pennsylvania Medicine. I have just incorporated and moved my office and your articles have been a great help.

This is certainly an area where all doctors need help and information. I hope you plan to continue to write these articles for quite awhile.

Richard F. Tignor, M.D.
Williamsport



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WRITE FOR LITERATURE AND SAMPLES

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First Symposium on Adolescent Medicine

DATE: Saturday, March 16, 1974

TIME: 9 a.m. to 4 p.m.

PLACE: Tri-Institutional Nurses Education Building
420 Service Drive (Grounds of Philadelphia General Hospital)
Philadelphia, Pennsylvania 19104

Registration Fee: $10.00 Luncheon will be served

Partial List of Faculty Includes:

Lester Baker, M.D.
Director, Clinical Research Center
The Children's Hospital of Philadelphia
Associate Professor of Pediatrics
University of Pennsylvania School of Medicine
Philadelphia, Pennsylvania

Willard Dalrymple, M.D.
Director, University Health Services
Isabella McCosh Infirmary
Princeton University
Princeton, New Jersey

Ronald Liebman, M.D.
Associate Director of Training
Division of Child Psychiatry
Philadelphia Child Guidance Clinic
Philadelphia, Pennsylvania

Thomas S. Morse, M.D.
Pediatric Surgeon
The Children's Hospital of Columbus
Associate Professor of Surgery
Ohio State University College of Medicine
Columbus, Ohio

Joseph N. Corriere, Jr., M.D.
Associate Professor of Urology
University of Pennsylvania School of Medicine
Hospital of the University of Pennsylvania
Philadelphia, Pennsylvania

Paul Gross, M.D.
Assistant Professor of Dermatology
University of Pennsylvania School of Medicine
Chief of Dermatology Division
Pennsylvania Hospital
Methodist Hospital
Philadelphia, Pennsylvania

Salvador Minuchin, M.D.
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Philadelphia Child Guidance Clinic
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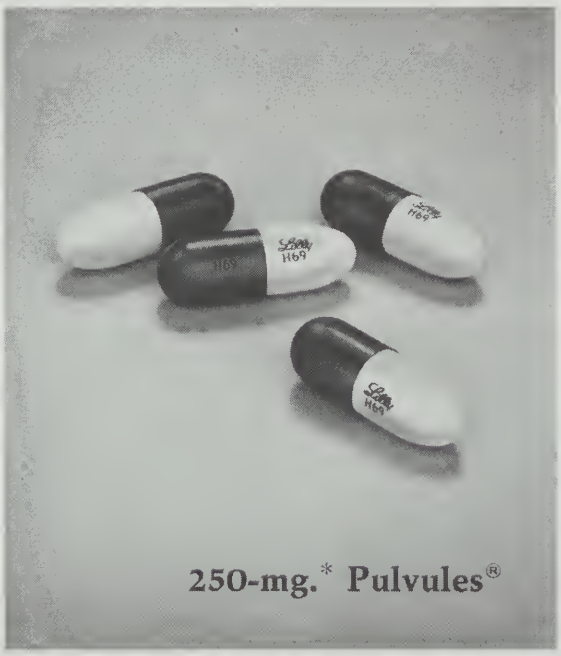

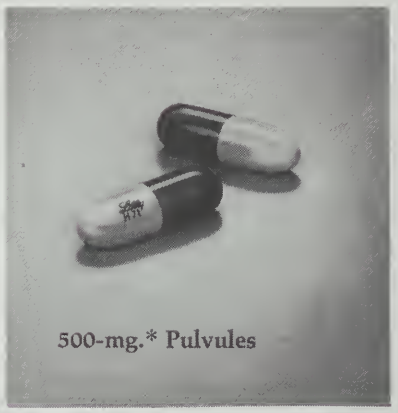

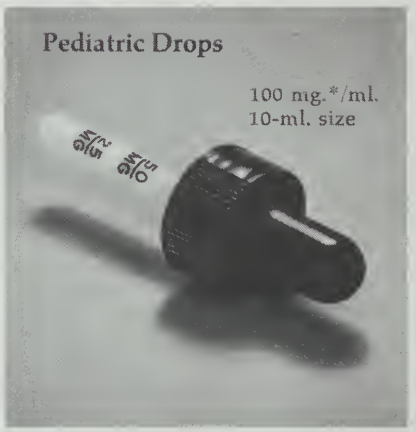

*Equivalent to cephalexin.

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TRAUMA! Evaluating lower urinary tract injury

EDGAR J. SANFORD, M.D.
Hershey

Intraperitoneal or extraperitoneal bladder rupture may occur following blunt or penetrating trauma to the lower abdomen and pelvis. Pelvic fracture is associated with a 10 percent incidence of bladder rupture. "Straddle injuries" usually occur from a fall and are associated with complete or partial tears of the anterior urethra. Complete transection of the urethra occurs in the membranous portion and is almost always associated with pelvic fracture.

Fig. 1. Retrograde urethrogram showing intact distal urethra with massive extravasation of contrast material into pelvis in patient with complete transection of the membranous urethra.

Fig. 4. Cystogram exposure in the anterior-posterior plane showing teardrop configuration of bladder indicating collection of fluid in pelvis. Extravasated contrast material is not readily apparent in this projection. The upper tracts are simultaneously seen due to the prior injection of contrast material for the intravenous urogram.

Mortality from bladder rupture and urethral injuries can be eliminated by prompt recognition and surgical intervention.

After the initial physical examination and the institution of management for any associated injury requiring immediate attention, the patient is moved to the emergency room radiologic unit and a plain film of the abdomen is made. An infusion urogram with 300 cc of 25 percent sodium diatrizoate is begun. Simultaneously, in the male, a retrograde urethrogram is obtained by injecting 25-50 cc of water-soluble contrast medium (sodium diatrizoate) with an asepto bulb syringe directly into the external urethral meatus. An oblique film is made. Extravasation of dye into the pelvis (Fig. 1) along with the inability to palpate the prostate gland (Fig. 2) indicates urethral tear or transection. If the urethrogram demonstrates an intact urethra (Fig. 3), or in female patients, a # 18 French Foley urethral catheter with a 5 cc bag may be passed into the bladder. Water-soluble contrast material may then be instilled into the bladder and exposures made in the anterior-posterior plane (Fig. 4) and both right and left obliques (Fig. 5). At least 300 cc of contrast material should be used.

It is imperative that another exposure in the anterior-posterior plane be made following the drainage of all contrast material from the bladder. Most frequently, it is this latter film that will demonstrate bladder rupture. While the retrograde urethrogram and cystogram are being performed, exposures completing the intravenous urogram are being made for purposes of evaluating the upper urinary tracts.

Dr. Sanford is assistant professor of surgery in the division of urology at the Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

This complete radiologic evaluation can be performed in 15 to 30 minutes and leaves very little question as to the presence or absence of significant urinary tract trauma.

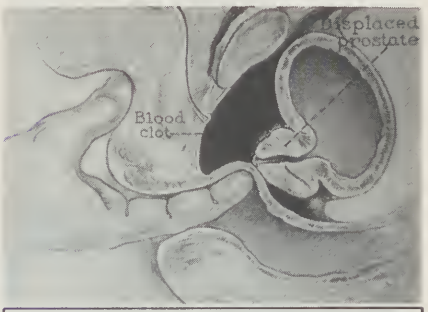


Fig. 2. Complete transection of membranous urethra depicting inability to palpate the displaced prostate gland—the pathognomonic "floating prostate" of this injury.

Fig. 3. Normal retrograde urethrogram.

Fig. 5. Oblique cystogram showing the bladder lying posterior to anterior extravasation of contrast material from bladder rupture.

Successful surgical treatment of false ventricular aneurysm

MONEIM A. FADALI, M.D. RENATE L. SOULEN, M.D. MILTON J. SANDS, JR., M.D.
GERALD M. LEMOLE, M.D. GERALD F. KAPLAN, M.D.
Philadelphia

MYOCARDIAL infarction is the most common cause of ventricular aneurysms. The lesion is said to occur in ten to fifteen percent of patients following acute myocardial infarction.[1] However, with the use of the present diagnostic tools which include electrocardiography, fluoroscopy, and ventriculography, an incidence of 25 percent is probably more accurate.[2] The lesion frequently affects the lateral and anterior walls of the left ventricle. Aneurysms of the posterior wall are rare because the papillary muscles supporting the mitral valve are attached to the posterior wall and a massive infarction in this area is likely to result in lethal acute mitral insufficiency. Pseudo-aneurysms of the left ventricle following acute myocardial infarction are exceedingly rare because in most instances rupture of this chamber leads to fatal hemopericardium. Our experience with and successful treatment of a giant false aneurysm of the posterior left ventricular wall are the subject of this report and literature review.

Figure 1A. PA film of the chest shows marked prominence and rounding of the left heart border which is partially obscured by left pleural fluid with normal right heart border, great vessels, and pulmonary vasculature.

Figure 1B. Lateral film shows considerable abnormal density posteriorly which cannot be separated from the cardiac silhouette and which has a well-defined convex superior border (arrows) clearly placing the density in the mediastinum.

Case Report

W. T., a 67-year-old man, was referred to Temple University Health Sciences Center with a diagnosis of intractable congestive heart failure secondary to post-infarction ventricular septal defect. He was hospitalized elsewhere seven months prior to admission with acute myocardial infarction. During that admission, left thoracentesis was performed twice for pleural effusion, and frank blood was obtained on both occasions arousing suspicion of a traumatic tap. Following discharge he remained in intractable heart failure in spite of rest and continued medication with digitalis, diuretics, and salt and water restriction. This necessitated readmission at another hospital where cardiac catheterization was undertaken and a thorough search made for an occult malignancy to explain his recent fifty to sixty pound weight loss. During catheterization, initial injection of the left ventricle showed what was thought to be a large ventricular septal defect. However, a second injection was not done, and the study was terminated due to an episode of pulmonary edema. The search for malignancy was negative. He was then transferred to Temple University Health Sciences Center for further evaluation and treatment.

Physical examination revealed a thin, chronically ill white man sitting in bed at an angle of 30° with respiratory distress. The heart rate was 108 and regular; blood pressure was 120/70. Neck veins were distended with a prominent A wave and a positive hepato-jugular reflux. Carotid pulse had a normal up-stroke and a rapid run-off. The point of maximal impulse was in the sixth interspace at the anterior axillary line with a diffuse impulse and a peculiar asynchronous rocky motion. There was a palpable S4, but there was no palpable 3 and no evidence of right ventricular hypertrophy. The pulmonary component of the second sound was accentuated and an early diastolic sound audible at the apex. There was a short ejection systolic murmur, and the aortic component of the second sound was followed by a 2/6 diastolic blowing murmur. Examination of the lungs revealed diminished tactile fremitus, dull percussion noted, and decreased breath sounds below the left scapula to the base of the lung. Fine rales were heard over the right base. The liver was tender and palpable five cm below the costal margin. Peripheral pulses were symmetrical and there was no peripheral edema, cyanosis, or clubbing. Neurologic examination revealed a mild organic brain syndrome with no evidence of focal neurologic deficit.

Laboratory studies on admission showed a hemoglobin of 11.3 and a hematocrit of 34.7 percent, a normal white blood and platelet count. The sodium, potassium chloride, CO^2, blood urea nitrogen, creatinine, prothrombin, partial thromboplastin, lactate dehydrogenase, serum glutamic oxaloacetic transaminase, and creatine phosphokinase were within normal limits. The electrocardiogram showed low QRS voltage, left atrial abnormality and nonspecific ST-T abnormalities. Pulmonary function tests revealed moderate degree of lung restriction with no airway obstruction and normal arterial gases. Admission

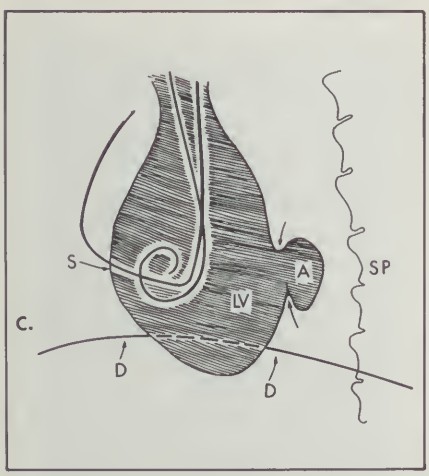
Figures 2A and 2B. Selected frames from left ventricular cineangiogram in left anterior oblique projection.

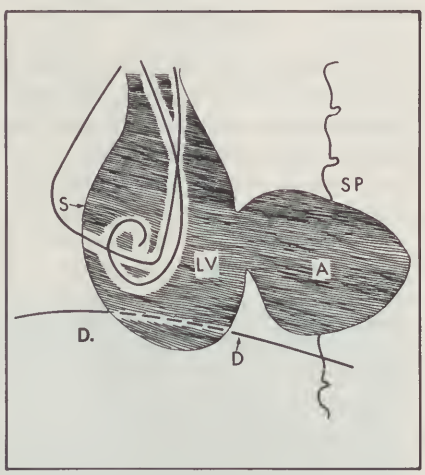
chest x-ray (Fig. 1) demonstrated marked left ventricular prominence suggestive of an aneurysm and a moderate degree of left pleural effusion. The pulmonary vasculature appeared normal. However, a cardiac series a few days later revealed progression to frank congestive heart failure with significant increase in the left pleural effusion and confirmed the absence of other cardiac chamber enlargement.

Cardiac catheterization demonstrated slightly elevated rightsided pressures which included right atrial pressure of seven with A wave of 10 mm Hg, right ventricle, 47/7, pulmonary artery, 38/10 (30) and a wedge of 20. The left ventricular pressure was 104/27. Cardiac output was 3.8 L/min with a cardiac index of 2.4 L/min/m^2 utilizing the Fick method. There was no abnormal step-up in oxygen saturation between the right cardiac chambers. Left ventricular injection in the left anterior oblique and right anterior oblique projections revealed a large aneurysmal sac originating from the posterior left ventricular wall and extending to the posterolateral chest wall (Fig. 2). Selective coronary arteriography demonstrated complete occlusion of the right coronary artery, 60 percent proximal stenosis of the left anterior descending, and diffuse irregularity of the circumflex.

On the tenth hospital day the patient was explored through a median sternotomy incision. After heparinization, cardiopulmonary bypass was instituted by cannulation of the superior and inferior vena cavae and the right femoral artery. The left ventricular chamber was vented via a catheter introduced through the left atrium. Ventricular fibrillation was electrically induced and the aorta cross-clamped before dissecting the aneurysm in order to avoid embolism by clots that might detach from the sac. The aneurysm occupied the entire lower left side of the chest and measured 22 by 12 cm. The sac was opened and a nonorganized thrombus loosely attached to the inner wall was removed. The aneurysm arose from the posterior wall of the left ventricle below the mitral valve annulus by a 2.5 x 1.5 cm opening. Three additional perforations, 0.2 cm in diameter, communicated the false sac with the left ventricular chamber. The sac was thin and consisted of fibrous tissue and adherent parietal pericardium. It was dissected from the left ventricle, left atrium, diaphragm, left lung, aorta, and esophagus. It was then excised and the left ventricular defect closed with mattress sutures of prolene reinforced with dacron buttresses. The heart was defibrillated; and, on terminating bypass, effective cardiac contractions were achieved. Due to the patient's poor general condition, it was elected not to add coronary artery bypass grafting[3-5] at this stage. The patient, who was in intractable heart failure prior to surgery, was discharged from the hospital in satisfactory condition and is doing well six months after surgery.

Microscopic examination revealed scarring of the left ventricular myocardium adjacent to the mouth of the aneurysm, consistent with the diagnosis of an old healed infarct. This scarring was continuous with the fibrous tissue layer that represented the wall of the pseudoaneurysm.





Figures 2C and 2D. Line drawings of A and B. Left ventricle (LV) which is somewhat enlarged; S—intact interventricular septum; A—contrast medium within the false aneurysm; Sp—thoracic spine; D—diaphragm. A pigtail catheter has been passed into the LV from a femoral artery; an NIH catheter courses from an antecubital vein into the pulmonary artery. Early during injection (A) contrast begins to enter the false sac. Note the small size of the mouth (curved arrows). A bit later this contrast extends over the spine; later still the sac was seen to extend to the posterolateral chest wall, but dilution was too great to permit satisfactory reproduction in print.

Discussion

Aneurysms of the heart may be either congenital or acquired. The congenital variety first described by O'Bryan in 1834[6] has been subdivided into diverticuloid and saccular. Diverticuloid aneurysms are much commoner and originate from the apex of the ventricle, penetrate through a diaphragmatic defect, and present in the epigastrium. Roessler[7] first successfully resected this lesion in 1944, and Davila[8] performed the first successful excision under cardiopulmonary bypass in 1964. The saccular variety is generally asymptomatic and discovered accidentally on radiograms

or at autopsy as pouches arising from the nonapical part of the left ventricle.

The subvalvular left ventricular aneurysms described in young African negroes[9] probably represent herniation through a congenital defect in the wall of the left ventricle.

Trauma can cause true and false aneurysms.[10] Blunt trauma more commonly leads to a true aneurysm formation, while aneurysms following penetrating wounds are almost always false. Successful repair of these aneurysms have been reported.[11,12]

Most myocardial infarction left ventricular aneurysms are of the true variety where the scarred myocardium forms the aneurysmal wall. The mouth of the aneurysm is as wide or wider than the diameter of the aneurysmal chamber. False aneurysms resulting from myocardial infarction are exceedingly rare since ventricular rupture usually leads to fatal cardiac tamponade. However, the pathophysiology may favor false aneurysmal formation if the leak resulting from rupture of a transmural ventricular infarct is contained by overlying pericarditis. In contrast to the true variety, false aneurysms may reach giant sizes; but the mouth of the aneurysm is always very narrow. Because of their continued enlargement, rupture of false aneurysms is an eminent threat in contradistinction to the very rare rupture of chronic true aneurysms.[1,13]

An interesting feature common to both varieties of aneurysm is the occurrence of thrombi in the sac, though these thrombi differ in nature. Thrombi in pseudoaneurysms generally remain fibrin because the sac is essentially avascular, while in true aneurysms thrombi usually organize and adhere to the wall. However, the small ostea of false aneurysms apparently reduce the incidence of systemic embolism with these lesions. At operation, the present case had loose nonorganized thrombi within the aneurysmal sac. To avoid systemic and coronary emboli during surgery, these aneurysms should not be handled before total cardiopulmonary bypass is instituted, the ascending aorta cross-clamped, and the heart electrically fibrillated. The incidence of emboli in pseudoaneurysms is difficult to ascertain due to lack of detailed reports on these rare lesions. So also is the incidence of arrythmias which have been encountered with this lesion. The hemodynamics of false aneurysms simulate mitral valve regurgitation since a portion of the stroke volume will be sequestered in the sac during systole. The sac being big in most cases, cardiac output is therefore significantly reduced and intractable heart failure frequently results.

The indications for resection are the same for the false and true varieties, namely intractable congestive heart failure, recurrent arrhythmias, and systemic embolization. The threat of rupture is an added and a prime indication for surgical resection of false aneurysms. Aggressive surgical therapy for these lesions is therefore warranted.

Diagnosis of post-infarction, left ventricular aneurysms can be suspected from the clinical picture, chest roentgenogram, and electrocardiogram. But a ventriculogram is essential to confirm the presence and establish the type of the aneurysm.

Our literature review revealed reports on seventeen patients with post-infarction false aneurysm.[13–22] Resection under cardiopulmonary bypass was reported in three cases. One case[22] has posterior wall, left ventricular aneurysm, but the patient succumbed during thoracotomy closure. In the other two cases[13] the aneurysm arose from the anterior ventricular wall, but no follow-up is reported.

Summary

The clinical and laboratory findings in a 67-year-old white man who had a false aneurysm of the left ventricle diagnosed seven months after acute myocardial infarction are reported. Aneurysm was successfully resected with the aid of cardiopulmonary bypass. The patient who was in intractable heart failure before surgery was discharged from the hospital in satisfactory condition and is doing well six months after operation. To our knowledge this represents the first successful resection of a post-infarction left ventricular false aneurysm. □

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Multiple agent chemotherapy recommended

Managing the acute leukemias

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THE introduction of aggressive, multiple agent chemotherapy for the treatment of the acute leukemias has lengthened survival times to a point at which some observers are discussing possible cures of the disease. These increased survivals have also led to a greater awareness of the problem of leukemic involvement of the central nervous system and the relative inability of the present chemotherapeutic agents to prevent or treat this serious complication.

Several studies have appeared in the literature regarding the management of acute childhood lymphocytic leukemia, but no series of patients with other leukemic cell types has as yet been reported.

It is the purpose of this paper to review the clinical entity of central nervous system leukemia and its relationship to the systemic disease and to discuss a new approach to its management.

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The clinical entity of leukemia was first described in 1845 by Virchow, Cragie, and Bennett, and the entity of acute leukemia in 1857 by Friedreich. Later authors subdivided the acute phase of the disease based on the predominant cell type, with acute lymphocytic leukemia representing about 70 percent of the cases.[12]

Between 1857 and 1948, when folic acid antagonists were first introduced by Farber and associates,[7] the disease was universally fatal, usually within a short time of the onset of symptoms.

Throughout those years, radiation was used primarily as a method of palliating local problems. More recent attempts to utilize extracorporeal irradiation in the definitive management of the disease have met with short-lived success.[18]

Since 1948, the introduction of systemic agents such as Prednisone, Vincristine, Daunomycin, 6-mercaptopurine, Methotrexate, Cyclophosphamide, Cytosine arabinoside, and l-asparaginase, used alone or in combination, has produced marked improvements in the length of initial remission and survival times.

Discussion

With prolongation of survival times, increasing awareness has come of the problem of leukemic involvement of the central nervous system or meningeal leukemia, defined as infiltration of the leptomeninges by leukemic cells.

Wintrobe,[20] in a study of 334 cases of acute leukemia, reports sixty-nine (20.5 percent) with clinical manifestations of central nervous system involvement. According to Skeel,[17] 50 percent of patients with acute lymphocytic leukemia will have evidence of central nervous system manifestations during the course of their disease, and Hyman et al[9] report an incidence of thirty-four (26 percent) in 132 children studied.

Intensive studies utilizing Methotrexate and 6-mercaptopurine[9] demonstrated conclusively that, in standard systemic doses, these agents failed to cross the blood-brain barrier in therapeutic concentrations. In general, there appears to be no significant relationship between the chemotherapeutic agents being used and the development of central nervous system leukemia (see Table I).

TABLE I

Leukemia Therapy and the Development of CNS Involvement[9]

Therapy	Number of Patients: Therapy Prior to Onset	Number of Patients: Therapy at Onset
Purine antagonists (6-mercaptopurine, thioguanosine)	53	18
Folic acid antagonists methotrexate	40	29
Steroids prednisone	39	6
Others	4	2
None	4	4

What is becoming more apparent and disturbing is the frequency of appearance of central nervous system involvement when the patient is in peripheral remission (see Tables II and III).

Farber[4] in a review of 974 children treated at the Children's Cancer Research Foundation reports the incidence of central nervous system leukemia in 40 percent. Patients in complete peripheral remission accounted for 54 percent of these episodes.

Pinkel[15] has reported that 30 to 50 percent of patients in peripheral remission will develop meningeal relapse prior to hemotologic relapse and that the meninges may represent the source of peripheral reseeding of the disease.

Clinically, central nervous system involvement can take the form of infiltration, hemorrhage, thrombosis, or tumor-like growths.

The signs and symptoms in order of frequency (see Table IV) include emesis, headache, lethargy, manifestations of increased cerebrospinal fluid pressure, ocular disturbances, cranial and peripheral nerve dysfunction, psychic disturbances, Cushing's syndrome, auditory disturbances, autonomic nervous system dysfunction, and speech disturbances.

Electroencephalograms are abnormal in approximately 75 percent, and skull x-rays will demonstrate signs of increased cerebrospinal fluid pressure in 51 percent.[9]

In review of 101 cases, Hyman et al[9] found that abnormalities of the cerebrospinal fluid occurred in ninety-five (91 percent) and consistently preceded the onset of clinical signs

TABLE II

Status of Systemic Leukemia at Onset of 109 CNS Episodes in 59 Patients[9]

	Status of Systemic Leukemia	No. Episodes
1.	No apparent disease	32
2.	Mild disease	25
3.	Moderate disease	34
4.	Advanced disease	18

TABLE III

Bone Marrow Findings at Onset of 109 CNS Episodes in 59 Patients[9]

	Marrow Rating	No. Episodes
1.	No evidence of leukemia	58
2.	Moderate leukemic involvement	9
3.	Marked leukemic involvement	42

TABLE IV

Signs and Symptoms of CNS Involvement Occurring in 59 Patients[9]

Secondary to Increased CSF Pressure (56 Pts.)	
Emesis	46
Headache	45
Papilledema	34
Lethargy	22
Vertigo	9
Nuchal rigidity	7
Convulsions	4
Coma	3
Proptosis	3
Hydrocephalus	1
Ocular Disturbances (21 Pts.)	
Diplopia	9
Strabismus	9
Blurred vision	8
Blindness	3
Photophobia	3
Nystagmus	2
Other visual disturbances	2
Cranial and Peripheral Nerve Dysfunction (13 Pts.)	
Facial paralysis	6
Hemiparesis	3
Paraplegia	3
Foot drop	1
Ptosis of eyelid	1
Psychic Disturbances (12 Pts.)	
Hyperirritability	8
Hallucinations	3
Catatonic Depression	1
Disorientation	1
Cushing's Syndrome (8 Pts.)	
Pathologic weight gain	8
Hirsuitism	1
Auditory Disturbances (5 Pts.)	
Hypoacusis	4
Hyperacusis	2
Autonomic Nervous System Dysfunction (6 Pts.)	
Hyperpnea	3
Cheyne-stokes Respiration	2
Fever	1
Hiccough	1
Tachycardia	1
Speech Disturbances (3 Pts.)	
Slurred Speech	2
Hoarseness	1
Asymptomatic Episodes (3 Pts.)	
Diagnosis by CSF	2
Diagnosis at autopsy	1

TABLE V

Initial Lumbar Punctures - 101 Episodes[9]

	Number Observed	CSF Values Range (Median)	No. Obs. Below Normal	No. Obs Normal	No. Obs. Above Normal
Opening Pressure mm. H_2O (N = <200 mm H_2O)	75	48-><600 (335 mm. H_2O)	——	7 9%	68 91%
White Cell Count/mm.^{3} (N = 0-10 cells/mm.^{3})	95	0-64,700 (547/mm.^{3})	——	15 16%	80 84%
Sugar mg. per cent (N = 50-80 mg. per cent)	71	2-130 (38 mg. %)	39 55%	25 35%	7 10%
Protein mg. per cent (N = 15-55 mg. per cent)	76	7-1,060 (34 mg. %)	2 3%	58 76%	16 21%

The percentages given are related to the number of instances in which the individual determinations were performed. Normal values are from Nelson, W. E.; Normal cerebrospinal fluid values. In Mitchell—Nelson Textbook of Pediatrics, 5th Edition, W. B. Saunders Co., 1950, p. 1609.

and symptoms stressing the importance of routine lumbar punctures (see Table V).

Cerebrospinal fluid findings included increased pressure, pleocytosis, increased protein, and decreased sugar. Nies et al[14] have defined meningeal leukemia as the presence of greater than 10 lymphocytes or mononuclear cells per mm^3 of the cerebrospinal fluid in the absence of positive bacteriologic culture or gross bloody contamination of the specimen. Five to ten cells were considered as evidence of possible meningeal leukemia.

Intrathecal aminopterin, first attempted in 1958[10] afforded good palliation in all patients who received a complete course, but the duration of remission averaged only nine weeks.[14] The drug was well tolerated with minimal systemic toxicity including nausea, emesis, abdominal pain, anemia, and thrombocytopenia.

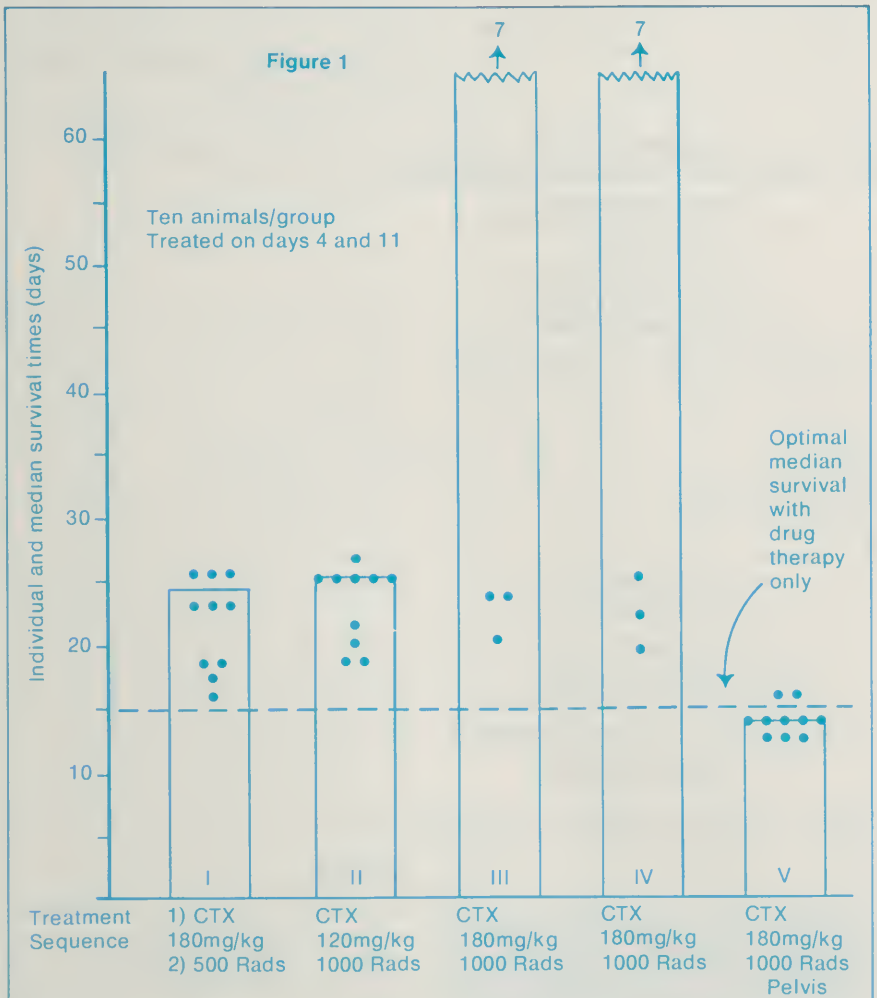
Administration of intrathecal aminopterin prior to the onset of leukemic cerebrospinal fluid involvement appeared to have little success in reducing the frequency of presentation.[2,12,14]

Intrathecal drug administration is unsuccessful for several reasons. First, high evenly distributed drug concentrations are mechanically difficult to obtain; and second, leukemic cells are sequestered in areas not accessible to circulating cerebrospinal fluid.

In 1964, Johnson[11] injected L1 210 leukemia intracranially into female CDF_1 mice. Three days after inoculation the mice were randomized into five groups and on the fourth day after inoculation therapy was begun.

The control group, which received no therapy, demonstrated a median survival of ten days. Group 2 received cyclophosphamide (Cytoxan® Mead Johnson Laboratories) intraperitoneally (0.01 ml/gm body weight) and had a median survival of fourteen days with no long term survivals. Group 3 received intraperitoneal cyclophosphamide plus irradiation to the cranium and spine (2 MeV electron beam). This group had a markedly improved median survival, with animals living longer than sixty days. Groups 4 and 5, which were treated by irradiation alone or cyclophosphamide plus irradiation to the pelvis, demonstrated short median survivals of less than fourteen days with no long term survivors (see Figure 1).

Figure 1



Median and individual survival times for animals receiving combined systemic Cytoxan and central nervous system irradiation • CTX = Cytoxan, Rad = Radiation; • = day of death of individual mice.[11]

Johnson's work led to formulation of the "sanctuary" theory—that leukemic cells sequestered in the central nervous system and immune to high doses of systemic chemotherapeutic agents because of the blood-brain barrier could act as a nidus for peripheral and marrow relapse.

Encouraged by Johnson's work, human trials were instituted to determine the efficacy of central nervous system irradiation prior to the laboratory or clinical diagnosis of central nervous system leukemia as a means of prolonging the period free of disease.

In 1965, George et al[6] reported the first series of clinical studies on patients with acute lymphocytic leukemia. Using a Cobalt 60 teletherapy device and delivering 500 rads to the cerebrospinal fluid axis, it was their finding that irradiation had no effect on the subsequent development of central nervous system leukemia or the prevention of peripheral relapse.

In 1968, George et al[7] reported a series of thirty-one children with acute lymphocytic leukemia who had received 1200 rads (Cobalt 60) over eleven elapsed days to the cerebrospinal fluid axis. Of the twenty-one patients no longer in remission at the time of the evaluation, central nervous system relapse had preceded hematologic relapse in twelve.

The duration from occurrence of central nervous system leukemia to hematologic relapse ranged from three to eighty-two weeks.

All patients tolerated the radiation well, with mild nausea and emesis, leukopenia, and alopecia being the only significant side effects.

Several authors have suggested the possibility that other organs, such as

the testicle, acted as sanctuary sites. However, an additional review of the St. Jude's Hospital experience between 1962 and 1965 demonstrated only one case of leukemic infiltration of the testicle in forty-nine male children with acute lymphocytic leukemia.

In 1971 and 1972, Aur et al[2] reported the use of "total therapy" in the treatment of acute childhood lymphocytic leukemia.

Based on an empirical sequence of goals, their aims were to (1) attain complete peripheral remission, (2) reduce the inapparent leukemic cell population, (3) prevent or delay central nervous system involvement, and (4) continue destruction of the subclinical leukemic cell population (see Table VI).

One hundred ten patients were entered into the study and received an initial course of systemic chemotherapy[2] (Prednisone and Vincristine) designed to attain the first goal. Complete peripheral remission was achieved in 94 percent within twenty-seven to thirty-nine days.

This was followed by a one week course of intensive chemotherapy (intravenous 6-mercaptopurine, Methotrexate, and Cyclophosphamide) to achieve the second goal and then randomization into two groups, one that received cerebrospinal fluid irradiation and one that did not.

Irradiation consisted of 2400 rads (Cobalt 60) to the cerebrospinal fluid axis over a two and a half week period. Children one to two years of age received 2000 rads and those under one year received 1500 rads.

Central nervous system leukemia terminated remission in only 4.4 percent of patients who received "prophylactic" irradiation, compared to 55 percent of those who did not.

Following irradiation, children still in remission were placed on continuation therapy consisting of 6-mercaptopurine, Methotrexate, and Cyclophosphamide. At ten-week intervals, brief courses of Prednisone and Vincristine were added.

Of the twenty-seven patients who developed central nervous system leukemia, hematologic relapse occurred shortly in six. All twenty-seven underwent subsequent central nervous system irradiation with evidence of response in twenty-five. Within five to twelve months, five patients had a second episode of central nervous system relapse.

All patients who remained in continuous initial remission for longer than twenty-eight months survived five years.

Mental, psychological, and growth patterns of children receiving central nervous system irradiation have been studied intensively.[3,12] The children scored average or better in school work. Pretreatment and posttreatment psychological studies demonstrated no impairment in intelligence, perception, or personality. Linear growth patterns, which slowed at first, demonstrated a subsequent "catch-up"[16] period during which the children reached an average pattern for their age.

TABLE VI
Outline of Therapeutic Regimen with Dosage Guidelines[3]

Remission Induction
(4-6 Weeks)

Pred 40 mg/M² orally daily
VCR 1.5 mg/M² IV weekly
Dauno 25 mg/M² IV weekly

If complete remission - 1st randomization

Group A	Group B
Intensive chemotherapy - 7 days 6-MP 1 g/M² IV daily X3 followed by MTX 1 Omg/M² daily X 3 followed by Cyclo 600 mg/M² daily X 1 day. 2 week delay between last day of intensive chemotherapy and continuation therapy	No Intensive chemotherapy No delay

Continuation Therapy
(3 years)

6-MP 50 mg/M² orally daily
MTX 20 mg/M² orally weekly
Cyclo 200 mg/M² orally weekly
Every 70 days of continuation therapy
Pred 40 mg/M² orally daily X 15
VCR 1.5 mg/M² IV weekly X3

After 4 weeks of complete remission - 2nd randomization

Group A		Group B	
A-1	**A-2**	**B-1**	**B-2**
2400 Rads Co^{60} craniospinal irradiation (4 weeks)	No irradiation until demonstrable CNS leukemia	2400 Rads Co^{60} craniospinal irradiation (4 weeks)	No irradiation until demonstrable CNS leukemia

Pred = Prednisone; VCR = Vincristine; Dauno = Daunomycin; 6-MP = 6 mercaptopurine; MTX = Methotrexate; Cyclo = Cyclophosphamide.

Summary

Following the achievement of initial peripheral remission, irradiation to the cerebrospinal fluid axis in doses of approximately 2400 rads are well tolerated and provide little morbidity.

Initial studies with acute lymphocytic leukemia have shown a significant improvement in the period free of disease as well as increased over-all survival times.

No large series has as yet appeared in the literature on the benefit of central nervous system irradiation in the other acute leukemic cell types. □

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Role of the family physician –

Changing care following heart surgery

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FOLLOWING major heart surgery, the burden of care shifts from the surgical team at a large medical center to the physician who resumes responsibility for his patient's care in his or her locale.

Therefore, the local family physician should be acquainted with some of the difficulties or complications that may arise as a result of the rather sophisticated surgery that has become available to these patients.

It is important that the family physician be cognizant of certain basic facts if he is to cope with any complications that may follow valvulotomies, valve replacements, etc.

(1) He should be acquainted with the original indication for the major cardiac surgery.

(2) He must be able to cope with arrhythmias which may arise and know which medications will convert an atrial fibrillation or a complete heart block back to regular sinus rhythm.

(3) He must see the patient at regular intervals so that medications may be altered if necessary.

(4) Although phonocardiogram or echocardiogram are the ideal methods for follow-up and evaluation, facilities are not always readily available. Therefore, reliance should be placed on auscultation with the use of a stethoscope. (The case report to follow shows the value of recognizing ausculatory signs that signal danger.)

(5) The family practitioner should have good rapport with those that can use noninvasive diagnostic procedures and be able to proceed to cardiac catheterization and surgery if indicated.

Case Report

C. S., a 35-year-old white female, had rheumatic fever at age twelve. She states that at age twenty a heart murmur was detected. She apparently had no symptoms of cardiac failure until age twenty-five following a third pregnancy. She then developed signs and symptoms of a classic mitral stenosis associated with congestive heart failure. At age twenty seven, in 1964, a mitral commissurotomy was performed with apparent good results. She was maintained on digitalis and diuretics and was able to handle her usual household duties.

However, in 1969, she started to show signs of progressive congestive heart failure; and, despite the use of digitalis, she developed atrial fibrillation. In spite of the fact that she had already undergone cardiac surgery, it was the opinion of the attending physician that the condition was deteriorating and that additional corrective measures should be considered.

She was then referred to a medical center with facilities to reevaluate her cardiac status. Her preoperative studies established that once again she had a tight mitral stenosis and a very significant tricuspid stenosis.

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Figure 1. Lateral view of chest showing malfunctioning valve.

Figure 3. Original tricuspid valve prosthesis indicating malfunctioning disk due to fibrin formation.

On May 8, 1969, open heart surgery was performed. A revision of her mitral commissurotomy was done as had been indicated by preoperative studies. Canal catheters were inserted through the right atrium after confirmation of the presence of tricuspid stenosis by digital palpation through the right atrial appendage. At this time, a tricuspid commissurotomy was performed with the usual result of gross tricuspid insufficiency.

A Number 3 Starr Edwards Disk Valve was inserted at the location of the tricuspid valve. The patient withstood the surgery well and had a noncomplicated recovery from the combination of a mitral commissurotomy and the insertion of a tricuspid valve.

Subsequently, she was referred back to her family physician and was seen at two week intervals, being maintained on anticoagulant and digitalis therapy. However, it was noted by auscultation that at times the audible click of the valve was not heard. This artifact was felt to be due to the collection of fibrin on the valve. When the audible click would return, the patient had symptoms suggestive of small pulmonary infarctions probably due to the dislodgement of the fibrin.

However, in October of 1972, the tricuspid valve prosthesis clicks were not heard for a long period of time (ten days). The patient was admitted to the hospital and a noninvasive cardiac survey indicated that the tricuspid prosthesis was fixed in a mid-open position (see Fig. 1 and Fig. 2).

At this time, a decision was made to replace the malfunctioning valve. It should be noted that this decision was prompted first by ausculatory findings by the primary physician which were substantiated by noninvasive cardiac evaluation and a repeat cardiac catherterization. As noted above, flouroscopy showed the disk of the prosthetic valve fixed in a mid-open position and the feeling was that this was due to fibrin or to disk variance because of swelling. The patient's echocardiogram indicated at this time that the mitral valve was not critically stenotic.

Therefore, on October 17, 1972, open heart surgery was performed and the original Number 3 Starr Edwards Disk Valve (Fig. 3) was replaced with a new Tricuspid Valve Bell-Type Prosthesis (Disk-type prosthesis, Fig. 4).

The patient's postoperative course was uneventful. At the present time she is being maintained on digitalis and anticoagulant therapy. She is able to perform her usual activities and is examined at regular intervals by her family physician.

Conclusion

In view of the fact that more patients are benefitting from cardiac surgery, some possible guidelines are reviewed for primary or family physician follow-up care to detect any developing complications. To support this premise, a rather unique case of the replacement of a tricuspid valve, possibly the first in the field, is presented. □

Figure 2. Echocardiogram indicating fixation of tricuspid disk valve. (A review of the literature indicates that this may represent one of the first studies depicting a foreign body jammed in the tricuspid valve.)

Figure 4. Chest film with new valve in place.

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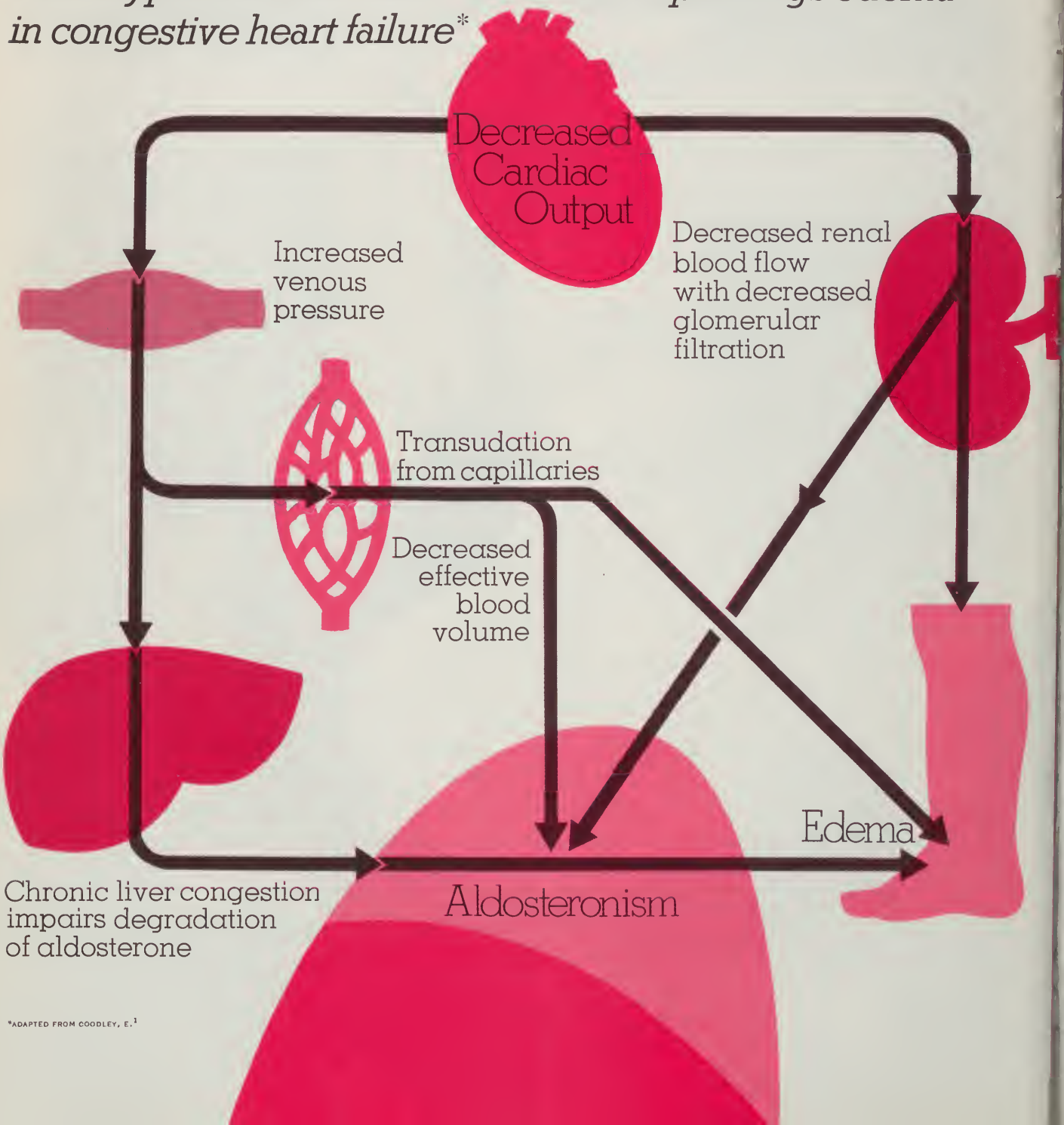
*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



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- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide
- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponotremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, otoxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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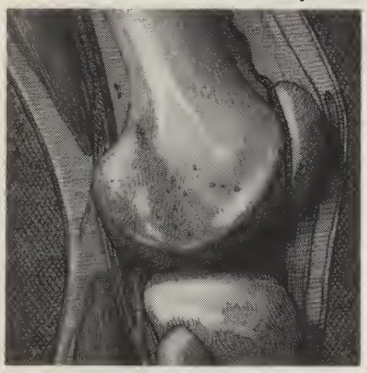

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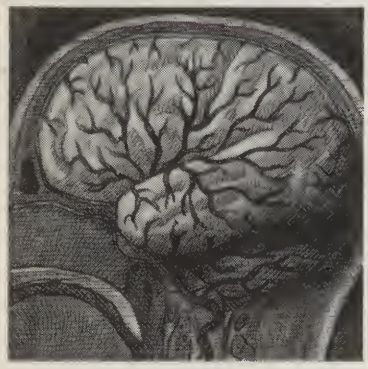

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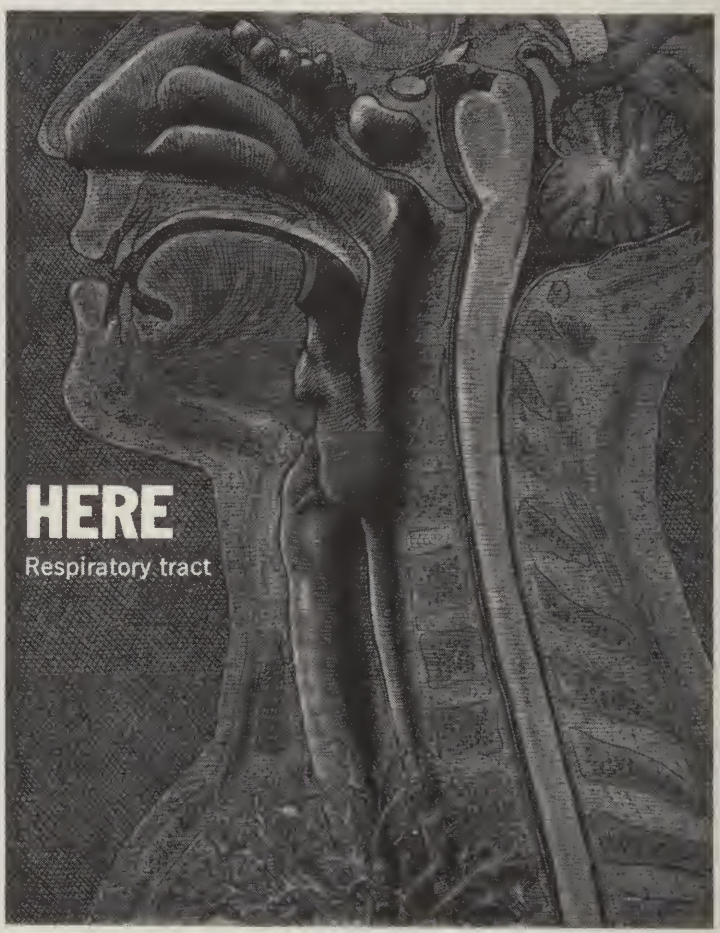

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Choloxin®
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AN IMPORTANT NOTE:
It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased by Increments of	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	monthly 1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	monthly 0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac Patients	0.5-1.0 mg.	monthly 1.0 mg.	4.0 mg.	4.0 mg.

Choloxin®
(sodium dextrothyroxine)

Description
CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3′,5′-tetraiodothyronine sodium salt.

Actions
The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications
This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following:
Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications
The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings
CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age
Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions
It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions
The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration
For **adult** euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For **pediatric** hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dosage should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

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Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

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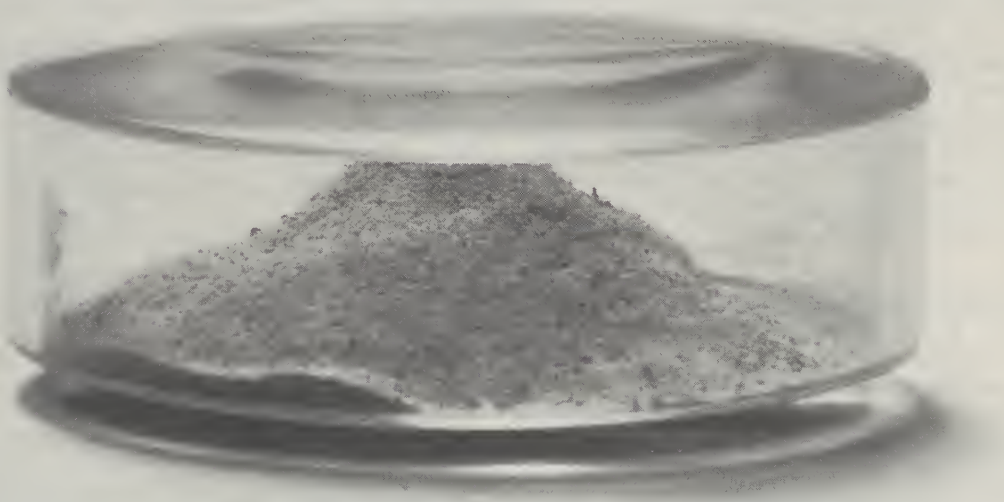

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Cardiologist, 29, American Board of Internal Medicine certified. Interest clinical cardiology, noninvasive techniques, catheterization. Seeking academic and/or practice. Write Department 638, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, Pa. 17043.

PENNSYLVANIA MEDICINE

continuing education

This issue carries no education course listings. New listings will be published in the March issue. If you would like to have a copy of the lists that were published in the December and January issues together with typed copy of new listings received since then, contact: Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

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• Indicates membership in the Pennsylvania Medical Society at time of death.

John V. Allen III, Rockwood; Hahnemann Medical College and Hospital, 1949; age 49; died October 9, 1973. He was director of clinics for the Bedford-Somerset County Mental Health-Mental Retardation office. There is no information regarding survivors.

• **Louis H. Averbach,** Philadelphia; Hahnemann Medical College, 1950; age 51; died December 5, 1973. He had been director of obstetrical and gynecological services at Frankford Hospital. He was a fellow of the Philadelphia Obstetric Society, the American College of Obstetricians and Gynecologists, and the American College of Surgeons. He is survived by his wife, a daughter, two sons, a brother, and his mother and father.

• **Francis F. Borzell,** Browns Mills, New Jersey; Jefferson Medical College, 1906; age 91; died December 12, 1973. Dr. Borzell was a former head of the radiology department at Frankford Hospital, Philadelphia. He was a past president of the Philadelphia County Medical Society and of the Pennsylvania Medical Society. He served as Speaker of the House of Delegates of the American Medical Association for a number of years. He was a member of the American Roentgen Ray Society, the Radiological Society of North America, and the American College of Radiology. He is survived by a daughter, a sister, and a brother.

• **Alexander H. Colwell,** Pittsburgh; University of Pittsburgh School of Medicine, 1914; age 86; died November 18, 1973. Dr. Colwell was President of the Pennsylvania Medical Society in 1935-1936. He had also served as president of the Allegheny County Medical Society. He had been professor of medicine at the University of Pittsburgh School of Medicine for more than fifty years. A son and a daughter survive him.

• **William F. Delaney,** Philadelphia; Hahnemann Medical College, 1934; age 69; died during 1973. No further information is available.

• **Robert L. Feldmann,** York; Yale University School of Medicine, 1933; age 67; died November 30, 1973. He was former chairman of the ear, nose, and throat department at York Hospital and was active in the Cleft Palate Clinic there. He was a fellow of the American College of Surgeons. He is survived by his wife, three daughters, a son, and two brothers.

• **Richard L. Goyne,** Wyomissing; Temple University School of Medicine, 1939; age 60; died November 5, 1973. He had been assistant state regional medical director for the Pennsylvania Department of Health at the West Reading office. He had been in private practice in obstetrics for fourteen years in Harrisburg prior to 1958. His wife, two sons, and a daughter survive him.

• **Frances J. Heath-Hughson,** Loudonville, New York; Woman's Medical College (Medical College of Pennsylvania), 1912; age 87; died during 1973. No further information is available.

• **William J. Hinkson,** New Castle; Jefferson Medical College, 1932; age 67; died September 11, 1973. He was a fellow of the American College of Surgeons. He is survived by his wife.

• **Martin D. Kishner,** Bala Cynwyd; Temple University School of Medicine, 1930; age 79; died October 18, 1973. He had practiced medicine in Philadelphia for forty-three years. His wife, two daughters, and two sons survive him.

• **Carl J. Konecke,** Wilkes-Barre; Hahnemann Medical College and Hospital, 1943; age 59; died October 22, 1973. He was a fellow of the American Academy of Family Physicians. Survivors include his wife; three daughters; two sons; a sister; and a brother, M. L. Konecke, M.D., Wilkes-Barre.

• **Alexander A. Krieger,** Pittsburgh; University of Maryland School of Medicine, 1932; age 68; died October 24, 1973. He is a fellow of the American Academy of Ophthalmology and Otolaryngology, the American College of Surgeons, the Panamerican Congress of Ophthalmology and was a past president of the Pittsburgh Ophthalmological Society. His wife survives him.

• **George H. Ledger,** Flagler Beach, Florida; Temple University School of Medicine, 1934; age 65; died November 28, 1973. He had been a physician in the Union City area for many years. Information regarding survivors is not available.

• **Edwin P. Longaker,** Ardmore; University of Pennsylvania School of Medicine, 1913; age 84; died December 10, 1973. He had been chief of the Bryn Mawr Hospital's department of otolaryngology. He is survived by his wife and three sons, Drs. Edwin D., William D., and Richard P. Longaker.

• **Pascal F. Lucchesi,** Philadelphia; Jefferson Medical College, 1926; age 69; died November 16, 1973. He was former vice president and medical director of Albert Einstein Medical Center and former medical director of Philadelphia General Hospital. He was a past president of the Philadelphia Medical Society, the Pennsylvania Public Health Association, and the Philadelphia Pediatric Society. He was a diplomate of the American Board of Pediatrics and of the American Board of Public Health and Preventive Medicine. Dr. Lucchesi had been professor of public health and preventive medicine at Hahnemann Medical College and Hospital. He was also a fellow of the American College of Physicians. He is survived by his wife and four daughters.

• **Kochuthundyil T. Mathew,** Erie; Christian Medical College, Vellore, India, 1951; age 54; died October 20, 1973. He was a staff physician at Hamot Medical Center. He is survived by his wife, his mother, three sons, and a sister.

• **Isaac L. Messmore,** Danville; Jefferson Medical College, 1940; age 59; died October 29, 1973. He was an associate in the department of obstetrics and gynecology at Geisinger Medical Center. He was a diplomate of the American Board of Obstetrics and Gynecology, a fellow of the American College of Obstetrics and Gynecology, and a fellow in the American College of Surgery. Survivors include his wife, a daughter, two sons, and a sister.

• **John H. Moore,** Lock Haven; Hahnemann Medical College, 1958; age 43; died November 14, 1973. Dr. Moore was a member of the staff and of the board of directors of Lock Haven Hospital and was clinician for the Lock Haven Tuberculosis and Health Clinic. He was a fellow of the American Thoracic Society and the American Academy of Family Physicians. Survivors include his wife, two daughters, four sons, his mother, two stepsons, two sisters, and four brothers.

• **Domer S. Newill,** Connellsville; Eclectic Medical College, Cincinnati, Ohio, 1915; age 82; died November 5, 1973. He was a surgeon in the Connellsville area. Survivors include his wife; three sons, two of whom are physicians, William K. Newill, M.D., Connellsville, and Domer S. Jr., M.D., Pittsburgh; a sister; and two brothers.

• **Thomas J. O'Meara,** Pittsburgh; Marquette University School of Medicine, Milwaukee, Wisconsin, 1941; age 57; died November 13, 1973. He was medical director for the Westinghouse Air Brake Company. He is survived by his wife.

• **Arthur E. Roose,** Green Valley, Arizona; University of Pittsburgh School of Medicine, 1929; age 72; died October 12, 1973. He was a fellow of the American College of Obstetricians and Gynecologists, the Pittsburgh Obstetrical and Gynecological Society, and the American Society of Abdominal Surgeons. His wife and two sons survive him.

• **James C. Schornick,** Clearfield; Indiana University School of Medicine, 1940; age 60; died November 1, 1973. He was chief radiologist at Miners Hospital, Spangler, and Nason Hospital, Roaring Spring. He was a fellow of the Radiological Society of North America. He is survived by his wife; three sons, one of whom is James C. Schornick, Jr., M.D., Spangler; and two sisters.

• **George H. Seaks,** New Oxford; University of Maryland College of Physicians and Surgeons, Baltimore, Maryland, 1904; age 96; died December 12, 1973. He had practiced in Harrisburg for many years. He was a fellow of the American College of Surgeons, the Pennsylvania Academy of Ophthalmology and Otolaryngology, and the American Board of Otolaryngology. He is survived by his wife, two sons, and a daughter.

• **Norman E. Snyder,** Lancaster; University of Pennsylvania School of Medicine, 1921; age 76; died October 13, 1973. He is survived by his widow.

• **Rodney L. Stedge,** Sayre; Jefferson Medical College, 1925; age 80; died October 13, 1973. He had been chief of the department of obstetrics at the Robert Packer Hospital until 1957 when he went into general practice. Survivors include his wife, two sons, and two stepdaughters.

Ruth S. K. Calehuff, Williamsport; Women's Medical College (Medical College of Pennsylvania), 1925; age 74; died July 29, 1973. No further information is available.

Andrew Harvey, Morgantown; University of Pennsylvania School of Medicine, 1925; age 79; died July 3, 1973. His wife survives him.

Norman H. Taylor, Hamilton, Bermuda; Harvard University Medical School, 1918; age 80; died July 19, 1973. His wife survives him.

PENNSYLVANIA MEDICINE

new members

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Tae Cheol Min, M.D., 900 Third Ave., Beaver Falls 15010.

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Harnish K. V. Shah, M.D., 202 S. Mansion Dr., Shillington 19607.

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Romeo C. Rosel, M.D., 310 Lortz Ave., Chambersburg 17201.

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Mary R. Schweikle, M.D., 1298 Hepburn St., Williamsport 17701.
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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in cystitis, pyelonephritis and pyelitis diagnosed as chronic and due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which appears on preceding page.

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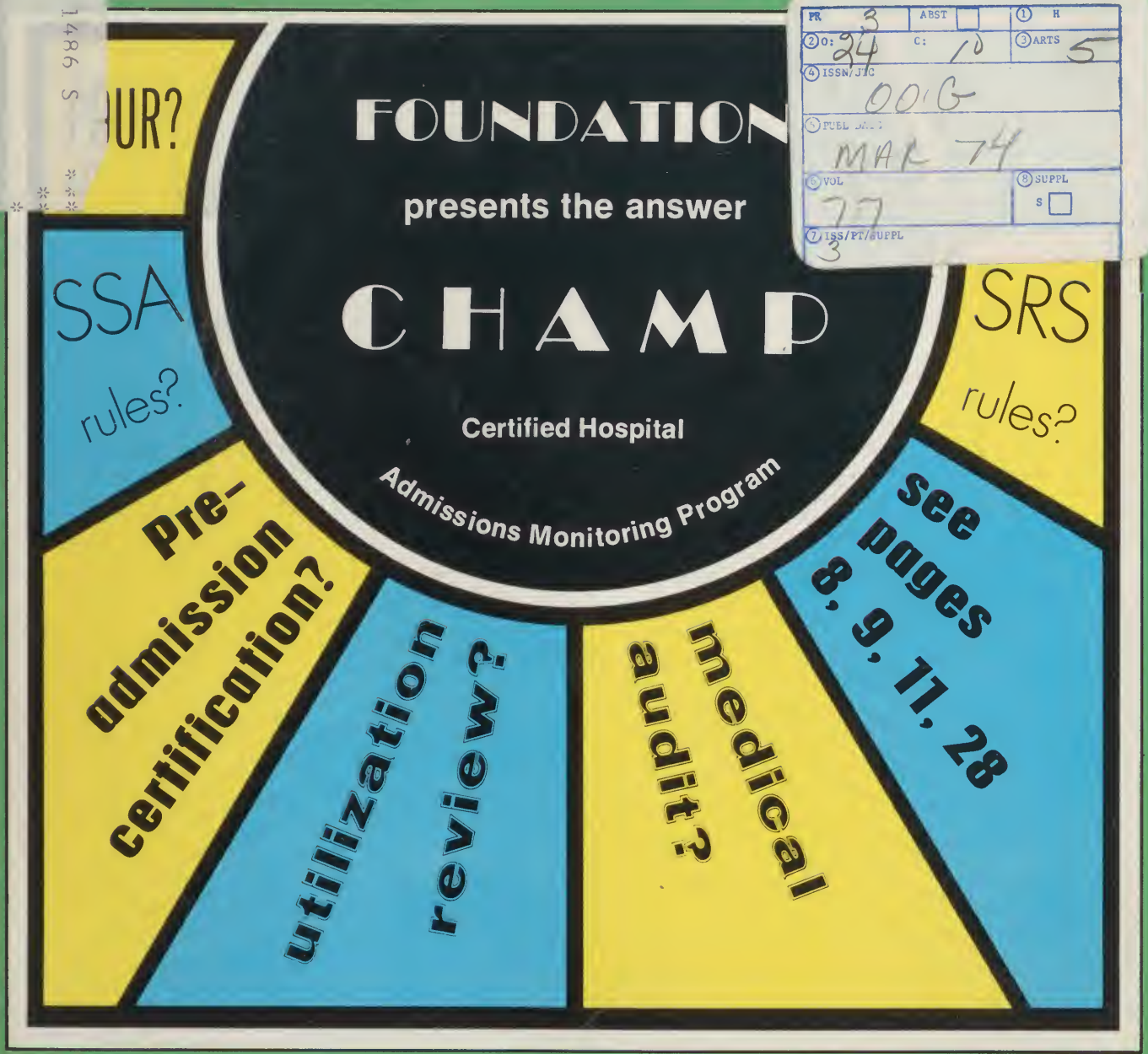
MARCH 1974



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PENNSYLVANIA MEDICINE medigram March 1974

AMA SUES TO END PHASE IV CONTROLS

The AMA on February 19 filed suit in U.S. District Court in the District of Columbia to seek an end to economic controls on medical care. Announcement of the action was made by AMA President Russell B. Roth, M.D., and Board Chairman James K. Sammons, M.D. It followed a request to Congress from President Nixon that all strict wage-price controls be ended by April 30--except on petroleum (covered by separate legislation) and health care. Dr. Roth said the controls "are so arbitrary as to be vindictive." He said the Phase IV regulations applied to physicians and hospitals are "confiscatory, arbitrary, capricious, and discriminatory. . .and violate the very law on which they are based in that they do not conform to the 'generally fair and equitable' standard written into the law by the Congress." Cost of Living Council Director John T. Dunlop testified earlier before a Senate subcommittee and recommended that mandatory controls on the health care industry be continued until Congress passes a national health insurance bill. Drs. Sammons and Roth also appeared before the subcommittee to call for an end to controls, testifying that they "are unfounded in the law" and that they "pose a grave threat to the quality and availability of medical care in this country."

PEER REVIEW PROTECTION MOVING

H.B. 1729, the bill drafted by the State Society to protect physicians participating in peer review activities, has been reported out of committee and is on second reading on the House of Representatives calendar. The House is in recess until March 4, but efforts to have an early vote when legislators return are being made. Peer review, as redefined by amendments to the bill "means the procedure for evaluation by professionals of the quality and efficiency of services ordered or performed by other professionals, including practical analysis, in-patient hospital and extended care facility utilization review, medical audit, ambulatory care review, and claims review." The Council on Governmental Relations has issued a call to all Society members to ask their representatives to support H.B. 1729 and to encourage quick action.

LEGISLATURE PASSES BILL AFFECTING EYE CARE

S.B. 570, which would permit optometrists with special training to use certain topical diagnostic drugs "designated by the Secretary of Health," has passed both houses of the Legislature by large margins and been sent to Governor Milton J. Shapp. Efforts of the State Society to have the bill recommitted so that legislators might have an opportunity to study it further were unsuccessful. The 1973 House of Delegates directed that the bill be defeated, not amended.

COUNCIL TO PURSUE MEDICAID FEE ISSUE

The Council on Medical Service intends to pursue the medicaid fee increase issue despite a refusal for a blanket exemption from

Phase IV rules from the Cost of Living Council. Meanwhile, physicians are encouraged to move individually to seek exemptions for the $2.00 increase for home and office visits. Read the article on page 30 of this issue for instructions.

DENENBERG RESIGNS: SEEKS SENATE NOMINATION Insurance Commissioner Herbert S. Denenberg has submitted his resignation as insurance commissioner effective March 29. He will seek the Democratic nomination for the U.S. Senate seat now held by Senator Richard S. Schweiker.

PaMPAC BOARD ELECTS R. William Alexander, M.D., of Reading, was elected chairman of the PaMPAC Board of Directors when it met in February. Serving with him as officers will be: Robert J. Carroll, M.D., Pittsburgh, vice chairman; R. Edward Steele, M.D., Harrisburg, treasurer; and Mrs. Robert S. Christman (Woman's Auxiliary representative), Harrisburg, secretary. These officers will form the board's Executive Committee along with William B. West, M.D., Huntingdon, immediate past president; and Paul S. Friedman, M.D., Philadelphia. Also elected were Mrs. Donald E. Harrop (Woman's Auxiliary), Phoenixville, assistant secretary; and Jerry L. Rothenberger, PaMPAC executive director, assistant treasurer.

STATE SOCIETY MONITORS FUEL SHORTAGE The Executive Committee of the Board of Trustees was instrumental in having physicians exempted from alternate day purchase of gasoline so that requirements may be filled without reference to inspection sticker numbers. In a letter to Leonard Bachman, M.D., Governor Shapp's health services director, the Society further stated that physicians should be exempted from any mandatory rationing plan which might be imposed.

FURTHER PLAN C STUDY OFFERED The Blue Shield Board of Directors at its February meeting found that the proposed Plan C. Fee Schedule did not contain the proper degree of relativity and ordered further study at a March 14 meeting.

MANAGEMENT SEMINAR SET The Council on Education and Science will sponsor a two-day practice management seminar May 10 and 11 at the Hershey Motor Lodge. Leif C. Beck, Ll.B., presiden of Management Consulting for Professionals, Inc., of Bala Cynwyd, will participate in and is assisting in developing the program which will carry Category I credit toward the Physician's Recognition Award and the education requirement for continued PMS membership.

ACUPUNCTURE SYMPOSIUM OFFERED A symposium on acupuncture open to interested physicians and paramedical personnel has been scheduled by the Division of Continuing Education of Hahnemann Medical College for April 1-3, 1974, in Philadelphia. Teruo Matsumoto, M.D., professor of surgery, who is conducting clinical resear in acupuncture, will direct the symposium. For details contact the Division of Continuing Education, Hahnemann, 230 N. Broad St., Philadelphia 19102, or telephone (215) 448-8263.

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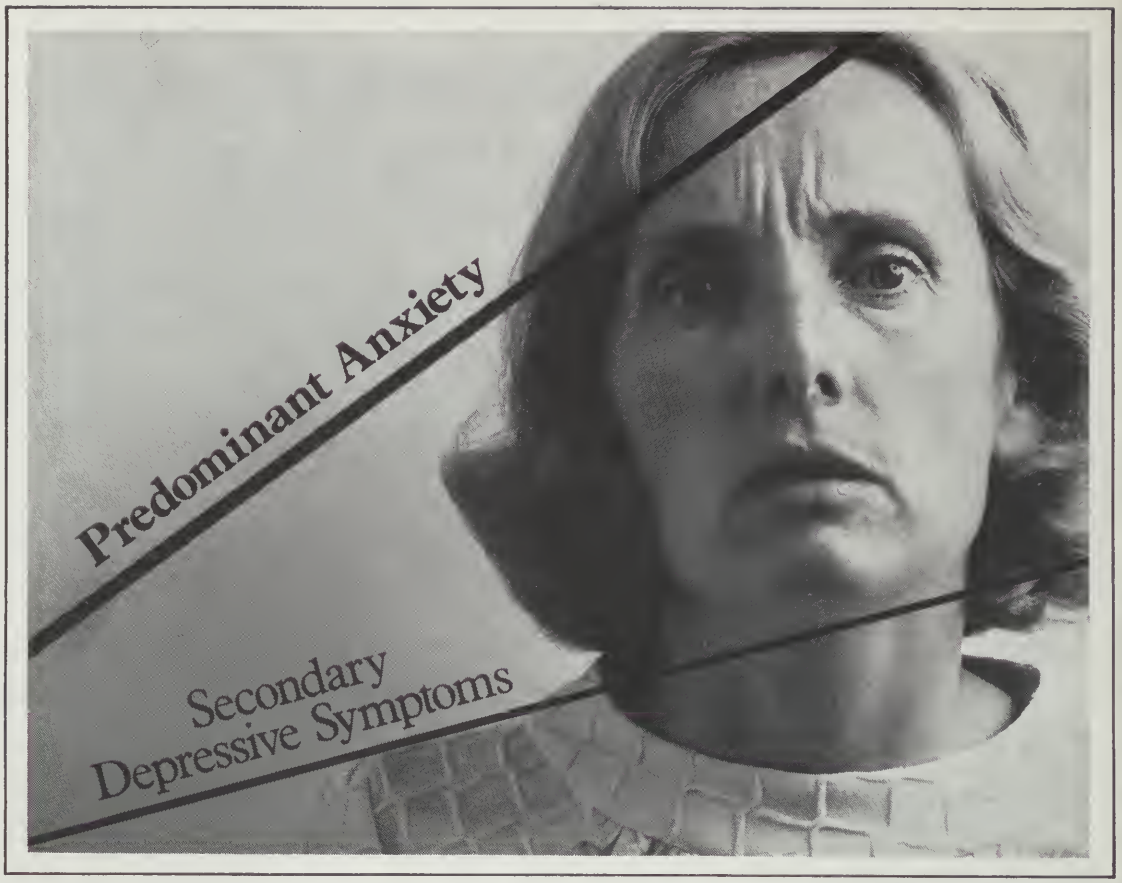

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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YOU should be RECORDING time spent in continuing medical education activities so that the information is readily available when you are ready to complete one of the application forms for the AMA Physician's Recognition Award.

Keep this new card in your wallet!

When you attend educational activities this spring and summer, record your attendance on the card.

It will take the guesswork out of transferring information to your file folder or to the PRA application form.

Time accumulated this spring cannot be reported on the 1973 PRA application form that you have now. It can be reported on the 1974, 1975, or 1976 application form which will be mailed directly to you from the AMA in the early summer of those respective years.

For additional cards for your wallet or for another folder for your file, contact:
Council on Education and Science
Pennsylvania Medical Society
20 Erford Road, Lemoyne, Pennsylvania 17043.

AMERICAN MEDICAL ASSOCIATION
Continuing Medical Education AWARD

Continuing education... now a PMS membership requirement

Education requirement conference highlight

Continuing Education has become a high priority item at the Pennsylvania Medical Society. To highlight this, the Officers' Conference Committee has assembled an expert panel on continuing education for the Thursday morning session, April 25, at the Host Inn in Harrisburg.

Reporting on forthcoming changes on the free-standing internship and foreign medical graduate situation will be William A. Sodeman, M.D., former dean and vice president of medical affairs for Jefferson Medical College, and more recently retired executive director of the Commission on Foreign Medical Graduates. Dr. Sodeman, of Medford Lakes, N.J., serves as chairman of the AMA Council on Medical Education.

Speaking on the State Society's accreditation program will be Fred D. Fister, M.D., a former general practitioner from Trexlertown, who for the past thirteen years has been director of medical education at Allentown Hospital. According to Dr. Fister, a member of the Society's Commission on Accreditation, since the Society initiated its accreditation program granting authorization to give Category One credit a year and a half ago, the commission has been processing an average of two applications a month. To date a total of twenty-one hospitals and organizations in Pennsylvania have been so authorized by the State Society. The objective is to provide convenient sources to earn Category One credit.

PRA to be Explained

C. H. William Ruhe, M.D., director of the AMA's division of medical education, will speak on the subject of continuing education. Dr. Ruhe, a Pennsylvanian by birth (Wilkinsburg), and a graduate and former associate dean of the University of Pittsburgh School of Medicine, has held the AMA's top medical education post since 1967. Editor of JAMA's annual issue on medical education and listings of continuing education courses, he is eminently qualified to report the AMA's plans for continuing education and to discuss the Physician's Recognition Award.

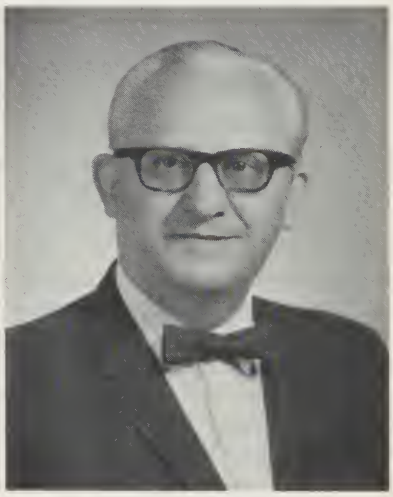
Of immediate concern is the Pennsylvania State Board of Medical Education and Licensure and its policy on continuing education. Speaking for the board will be its chairman, John W. Robertson, Jr., M.D., of Philadelphia. Dr. Robertson, a board certified surgeon, is on the staffs of Albert Einstein Medical Center and the John F. Kennedy Memorial Hospital.

According to Officers' Conference chairman, R. William Alexander, M.D., of Reading, the panel on continuing education is just one example of the quality speakers lined up for this year's meeting.

Other Highlights Listed

The 1974 Officers' Conference opens Wednesday, April 24, at 2:00 p.m. at the Host Inn, Harrisburg, with a "Report to the 'Stockholders' " by Executive Vice President John F. Rineman. Other highlights include an hour devoted to medical political action (PaMPAC) and a presentation on medical staff law and bylaws by Charles Jacobs, Esq., of the Joint Commission on Accreditation of Hospitals. The dinner speaker is the well-known Washington political satirist, Mark Russell.

To be certain of room reservations, county society officers should contact Robert L. Lamb at Society headquarters now.



DR. SODEMAN

DR. RUHE

DR. FISTER

DR. ROBERTSON

HEW pulls back on preadmission certification

Pre-admission certification as part of the HEW proposed medicare/medicaid utilization review regulations is dead — at least for the time being.

With the thirty-day comment period on the proposed regulations coming to a close last month, a top level AMA delegation paid a visit to President Nixon. After expressing to the President organized medicine's strong opposition to the regulations' pre-admission certification requirement, the delegation then went to see HEW Secretary Caspar Weinberger. Weinberger announced to the group that he had heard from the President and had decided to kill the pre-admission certification portions of the regulations.

At the same time Weinberger announced a thirty-day extension to the comment period for the surviving portions of the regulations.

Proposed rules published in the *Federal Register* by the Department of Health, Education, and Welfare on review of utilization of care and services in hospitals for medicare and medicaid patients have provoked comment and criticism from a number of sources, including the Pennsylvania Medical Care Foundation.

The regulations caused HEW's own Professional Standards Review Organization Advisory Council to adopt a resolution in opposition to the mandatory pre-admission certification for elective admissions called for in the proposal. This action was taken even though in the introduction, the proposed rules state that the standards proposed "have been so developed that they are aligned and supportive of the implementation of Professional Standards Review Organizations (PSROs), in order to assure effective administration of health care services."

Dr. Roth Speaks for AMA

Opposition of the AMA was voiced by Russell B. Roth, M.D., president, who said, "We are here today to serve notice on Secretary Weinberger [of HEW] that if he proceeds with the two proposed actions, we are going to take him to court."

The two proposals referred to are for the utilization review of services provided under medical assistance programs administered by the Social and Rehabilitation Service, and for utilization review of services for the aged and disabled administered by the Social Security Administration.

At his press conference, Dr. Roth called the proposed regulations "a direct threat to the 35 million or so patients who are served by medicare and medicaid."

Violates Law's Letter, Spirit

He added, "Any such denial of medical care represents a clear violation of both the spirit and the letter of the medicare-medicaid law. . . The Secretary has no authority under the guise of regulations to amend the law and reduce benefits [by utilization committee pre-certification of admission] . . . The medicare-medicaid law provides for pre-admission certification by the patient's physician and for post-admission review by hospitalization utilization review committees. The Congress did not intend that a committee substitute a paper decision for the judgment of the patient's physician.

"We are here to serve notice on the Secretary that if he persists in putting the regulations into effect, the AMA will seek an injunction on that very same day to stop him. We would welcome support from all interested parties, such as senior citizen organizations and consumer groups."

Foundation Comments

Comments filed by the Pennsylvania Medical Care Foundation point out a number of discrepencies between the proposed regulations and the PSRO law, particularly in the areas of conducting review and cost. An analysis of the Foundation's comments appears in this issue on page 11.

Quality assurance is PSRO study goal

Four professional health organizations, the American Society of Internal Medicine, the American Association of Foundations for Medical Care, the American College of Physicians, and the American Hospital Association are participants in a project to incorporate a greater emphasis on quality assurance into Professional Standards Review Organizations (PSROs). The project has been funded by a million dollar grant from the W. K. Kellogg Foundation to the Institute of Professional Standards for a two-year demonstration and operational study of PSROs.

These four major organizations believe that there is an urgent need to build on existing experience and capabilities with utilization review and quality care assessment to establish usable guidelines for peer review.

A priority item is establishing an effective relationship with the public in assessing the quality of care. They will define existing needed capabilities for data-processing, establish agreements with fiscal intermediaries, and integrate these requirements into blueprints for the future guidance of PSROs, while evaluating the relative costs of quality and utilization review as they will affect the total cost to the patient.

The study of the Institute of Professional Standards has received the endorsement of several other specialty societies.

Course date changed

The date of the acupuncture symposium to be presented at the University of Pittsburgh has been changed to April 20, 1974—rather than the date published in the February issue of PENNSYLVANIA MEDICINE.

For further information, contact William M. Cooper, M.D., Director of Continuing Education, University of Pittsburgh School of Medicine, 1022H Scaife Hall, Pittsburgh, Pa. 15261.

PSRO-CHAMP-PDUR confusion dissipates!

Dr. Marshall answers questions on review mechanisms

This issue of Pennsylvania Medicine contains several articles on methods of utilization review and federal government proposals to enforce such review. Questions rose even as members of the Communications Division and the staff of the Pennsylvania Medical Care Foundation worked on the material. We posed some of these to Matthew Marshall, Jr. M.D., of Pittsburgh, Foundation president. The answers appear below. If you have questions or comments, let us hear from you. Read the related articles on pages 8, 11, & 28.

Dr. Marshall, why should State Society members and members of the Pennsylvania Osteopathic Medical Association become involved through their organizations in establishing Professional Standards Review Organizations (PSROs)?

In the absence of PSRO, authorized under Section 249F of Public Law 92-603, certain other utilization and quality control provisions apply. Section 250 of the same law places responsibility in the hands of a single state agency. Our objections and those of the AMA and other organizations to the regulations published in the January 9, 1974 *Federal Register* are publicized in this issue of Pennsylvania Medicine and have appeared elsewhere. Further than that, however, Section 207 reduces or denies financial assistance to states unless they have established certain review procedures. Section 215 describes conditions under which physicians and hospitals may or may not bill medicare beneficiaries and gives responsibility of administrative decisions to fiscal intermediaries. If this isn't enough, program review teams are authorized under Section 229.

So what is the difference?

If we default in organizing PSROs, these little publicized sections of the law provide a basis by which medical care will be monitored without any mandate for local physician involvement. This would once again prove the theory of the uncanny ability of humans to find a way, if there is one, to make things go wrong.

What advantage is there to proceding as soon as possible?

The sooner the process is begun, the sooner the responsibility for quality and cost controls of medical care provided under government programs will be delegated to local physicians.

Are there any sources of information available to assist local physicians in organizing PSROs?

The Department of Health, Education, and Welfare (HEW) is developing guidelines which should be available in March. The AMA is working on a manual on the subject. County medical societies and the Pennsylvania Osteopathic Medical Association will be kept informed of developments by the Foundation as soon as possible.

What can be done now to prepare an application to become a PSRO?

One qualification for a PSRO applicant is clear. It must demonstrate the support of local physicians or their organizations. Except for Allegheny and Philadelphia Counties, local PSRO boundaries in Pennsylvania include more than one county and do not conform to any unit of organized medicine. The Foundation suggests that county medical societies and osteopathic medical societies meet and elect in each designated area a PSRO steering committee to consider geographic areas, physician concentration, and available knowledgeable physicians in its composition. This already has been done in PSRO Area IX (South Central Area).

What assistance is available from the Foundation?

The Foundation staff and officers have written to all societies offering assistance in arranging such meetings. I further suggest that members of the Board of Directors of the Foundation be called on for assistance. Limited funding has restricted us in expanding the Foundation staff to the necessary level, but I am hopeful that an agreement with HEW will make possible an expansion of professional and administrative services to county societies and hospital medical staffs.

Should steering committees proceed to develop articles of incorporation and bylaws?

In my opinion, not at this time. PSROs must either be incorporated or be a component of an incorporated organization. They must also meet other conditions not yet finalized by HEW. At this time the advantages or disadvantages to a PSRO in being a component organization are not clear. It is possible that the organization which forms the PSRO may continue as a component of the Pennsylvania Medical Care Foundation or may remain an independent medical care foundation to perform functions other than those of a PSRO and, therefore, would not want bylaws governing such functions based exclusively on federal guidelines. The Foundation is incorporated, and I suggest that the steering committee organize as an ad hoc regional steering committee until there is a better basis for and more time to consider organizational details.

Some people believe that the PSRO law will be repealed, making all this activity a waste of time. What is your assessment?

The AMA has stated that there is no current political viability in an effort to repeal the law. I agree with that, but

(Continued on page 31)

Cooperative membership campaign starts this month

The Society's recruitment campaign for members in the Physicians' Cooperative for mass purchasing will be initiated this month with a special mailing to the State Society membership, Robert N. Moyers, M.D., of Meadville, chairman of the Council on Public Service, has announced.

The House based its decision to proceed with plans for a cooperative for mass purchasing of supplies after receiving the results of an independent survey of Society members which showed that "supplies are often purchased in an impromptu, inattentive manner, and with almost complete indifference to price."

The cooperative is scheduled to begin operations in 1974 with a limited line of high volume items used daily in physicians' offices.

In order to be activated, however, the cooperative must have a minimum membership of 2,000, L. Riegel Haas, acting director of professional relations for the Society, said. The Board of Trustees authorized an expenditure of up to $25,000 for membership recruitment and start-up funds in keeping with the House action on the issue.

The Council on Public Service has had the plan under study for over two years and made a preliminary report to the House of Delegates in 1972 regarding the cost of office practice and the possibility of saving through mass purchasing. A random sampling of 12 percent of the Society's membership conducted by the council showed that nearly 70 percent favored a form of mass purchasing to cut costs.

H. Robert Davis, M.D., of Boiling Springs, chairman of the Cooperative Advisory Committee of the council said, "If the cooperative is to be born with a reasonable expectation of success, we must have a minimum membership of 2,000 physicians who have purchased a share of stock. One share, a lifetime membership in the cooperative, will cost $100."

Dr. Davis added that if the minimum 2,000 members fail to join, all funds will be returned to those who have purchased a share. "Even after the cooperative is formed," he added, "doctors may drop out by selling their membership certificate back to the cooperative for all, or a significant portion, of their initial investment . . . there is everything to gain and nothing to lose by becoming a charter member now."

The Council on Public Service expects that the membership response will be such that by its June 15 meeting it will be in a position to determine whether or not to proceed with the plan.

The Physicians' Cooperative, as a non-profit corporation, will turn back any profits to the members. Only State Society members will be able to join.

Society testifies at hearing on PA bill

SAMUEL G. WATTERSON, M.D., of Boswell, member of the Society's Council on Education and Science, came to Harrisburg last month to testify to the Society's agreement with the intent of H. B. 1469, "that the State Board of Medical Education and Licensure begin to organize the many identifiable paramedical disciplines." He appeared before the House Committee on Health and Welfare when a hearing on the physician's assistants bill was held. Dr. Watterson is shown above, second from left, with Representatives Jay R. Wells, III (Allegheny) and Charlotte D. Fawcett (Montgomery). On the far right is Robert H. Craig, Jr., the Society's director of governmental relations. Shown below at the hearing are Craig, Dr. Watterson, and Kenneth B. Jones of the Society's staff. Representative Patricia A. Crawford (Chester) who chaired the hearing, is shown below in the photo on the right with Michael Rosenstein, executive director of the Committee on Health and Welfare.

Foundation comments on HEW proposed review rules

The majority of the January 9 Health, Education, and Welfare (HEW) proposed medicare/medicaid utilization review regulations are still alive and dangerous according to the Pennsylvania Medical Care Foundation—despite the death of mandatory pre-admission certification contained in the proposed rules.

Shortly after the draft regulations made their appearance in the *Federal Register,* the Foundation, acting as Society spokesman, sent HEW a five-page statement chastising the federal agency for wasting time on regulations "which will interfere with Professional Standards Review Organizations (PSROs) development."

At the same time, both the Allegheny and Philadelphia County Medical Societies asked their members to launch a letter-writing campaign against the proposed regulations. In its *Executive Report,* the Society also called on physicians across the state to write HEW, opposing the rules.

Copies of the Foundation's comments on the HEW proposals were also provided to presidents of medical staffs in all of Pennsylvania's hospitals. Accompanying the comments was an outline and explanation of the Foundation-developed Certified Hospital Admissions Monitoring Project (CHAMP), which the Foundation explained was a much more appropriate means for conducting utilization review (For details on CHAMP, see page 28).

Matthew Marshall, Jr., M.D., president of the Foundation, said that CHAMP allows the hospital flexibility to adapt the system to meet its individual needs. He noted that CHAMP meets present medicare and medicaid review requirements and is also in line with PSRO implementation.

The opening paragraphs of the HEW proposal claim that the regulations' standards were developed to be "Aligned and supportive of the implementation of Professional Standards Review Organizations (PSROs)." Despite this statement, the Foundation analysis noted no less than six major conflicts in the would-be rules with existing PSRO law.

But even more alarming, the Foundation said, was the fact that "the proposed regulations suggest that the state medicaid agency will make a judgment as to the effectiveness of the individual utilization review committee, rather than the local PSRO." However, the Foundation said that neither guidelines for determining the effectiveness of the state's review nor the method for conducting that review are contained anywhere in the proposed rules.

Other sections of the regulations would "preclude hospital personnel such as a director of utilization or a utilization coordinator from participating in the hospital's utilization system," the comments noted, adding that this was also in conflict with PSRO law.

The Foundation statement attacked the proposed regulations for emphasizing a desire to reduce costs without indicating any concern for assuring the quality of care.

"The proposed regulations are silent as to how consumers or taxpayers may be assured that all review is in the interest of encouraging the proper provision of high quality medical care to recipients and that such review will not discriminate against the poor and the aged," the Foundation said.

The Foundation also pointed to several sections of the proposed rules that were not only vague, but apparently in conflict with themselves.

"It would seem far more appropriate for HEW to direct all efforts to the implementation of PSROs rather than to implement these regulations which will interfere with PSRO development. Furthermore, these regulations are medically inappropriate, regardless of their interference with PSRO implementation," the Foundation concluded.

Pittsburgh M.D. installed

At the annual meeting of the American Academy of Orthopaedic Surgeons, William F. Donaldson, M.D., of Pittsburgh, was installed as first vice president. He will accede to the presidency in 1974.

Dr. Donaldson is clinical professor of orthopaedic surgery at the University of Pittsburgh School of Medicine. He is a past president of the Pennsylvania Orthopaedic Society, a member of the American Orthopaedic Association, the International Society of Orthopaedics and Traumatology, the American Association for the Surgery of Trauma, and the American College of Surgery.

Society honors two students

The State Society has honored two students in the Essay on Aging Award sponsored by the Council on Education and Science. The Board of Trustees approved a recommendation from the council to award $100 to Gary Lee Grove of Pennsylvania State University; and to honor with a plaque of honorable mention Bonnie O'Rourke, a graduate of Drexel University.

The winning essay was entitled "Variations in cytochemical properties of the human diploid cell nuclei as a function of in vitro age." The plaque of honorable mention was awarded for a paper entitled, "The Future of Aging in America."

Nutrition survey scheduled

Martin E. Kodish, M.D., medical officer of the U.S. Public Health Service, has informed the Pennsylvania Medical Society that a health and nutrition examination survey will be made in Philadelphia County and in several adjoining New Jersey areas beginning March 25.

U.S. Bureau of Census interviewers will make household surveys from which about 365 persons between the ages of one and seventy-four years will be selected to participate in examinations at a mobile center. Statistics on the nutritional status of the age group from one to seventy-four and the health status and medical needs of the age group from twenty-five to seventy-four years of age are the objectives of the study.

Special packaging for oral prescriptions begins in April

Oral prescription drugs are being added to the list of hazardous substances which must be packaged in child-proof containers beginning in April 1974.

In addition to safety caps, the approved packaging may include any container which is sufficiently difficult for a child to open, according to the Food and Drug Administration (FDA). The action is being taken under a law enacted in 1970 which calls for the packaging in child-proof containers of hazardous substances which may cause serious illness to children.

Already excepted from the regulation are nitroglycerin, because it must be readily available for emergency use by the elderly, but which must be dispensed in its original sealed packet; and oral contraceptives, because of the importance of retaining the present packaging which is an aid in complying with dosage regimen. Other exceptions are being considered, according to the FDA.

Aspirin was the first drug to require safety containers, but the FDA says other over-the-counter preparations are being studied with regard to the need for safety containers.

Either the physician or the patient may request conventional packaging for prescription drugs.

Trust aids students

The Educational and Scientific Trust of the State Society provided scholarships and loans of $178,400 to 180 medical students in 1973—$30,000 more than in 1972. An action by the House of Delegates in 1973 called on members to begin to contribute or to increase contributions to the trust to support the loan program and the loan forgiveness program which would place new physicians in areas of need (See PENNSYLVANIA MEDICINE. November 1973). Contributions are tax deductible.

Fifty-year awards presented

Fourteen Allegheny County Society Members were presented with Pennsylvania Medical Society Fifty-Year Awards at the recent annual dinner dance of the society. They are: Drs. Hyman E. Cantor, Catherine M. Clare, Irene D. Ferguson, Thomas G. Ferguson, John E. Holt, Joseph Loughrey, William M. McNaugher, Peter G. Motta, Isadore Pachtman, Hugit B. Robins, Samuel J. Rosen, Joseph A. Soffel, Clarence W. Waring, and George A. Zuck.

Practice management workshop scheduled

A workshop entitled "Establishing Yourself in Medical Practice" is being planned March 18 and 19 at the Host Inn, Harrisburg. The Pennsylvania Medical Society and the American Medical Association are cosponsoring the program which is especially designed for senior residents who plan to set up private practices in solo, group, or institutional settings.

Instructors are professional management consultants. Materials covered are recruiting, interviewing, and utilization of personnel; patient flow techniques; medical records and billing systems and controls; office setup and equipment; and legal, tax, and insurance problems.

The workshop is limited to twenty-five. The registration fee of $35 for AMA and PMS members and $60 for nonmembers, includes a workbook manual which can later be used as an office manual.

Similar programs will be offered at later dates for practicing physicians, the first of which is scheduled for May 10-11 at a location not yet chosen.

Further information may be obtained from LeRoy Erickson, Director of Educational Activities, PMS Headquarters, 20 Erford Rd., Lemoyne, Pa. 17043. Telephone (717) 238-1635.

Chiropractic theory erroneous, study finds

According to the first experimental study of "subluxation" of the spine, chiropractic theory is erroneous. The study was conducted by Edmund S. Crelin, Ph.D., professor of anatomy at Yale University School of Medicine, and was published in the September-October issue of *American Scientist*. Dr. Crelin studied the effects of pressure applied to the vertebral columns of six individuals within six hours after death. He observed that "the nerves did not become unduly stretched when the column was maximally twisted."

The AMA has assumed all costs of obtaining reproduction and distribution rights of the paper. There is a minimum cost for shipping and handling costs for bulk orders as follows: For up to 100 copies, the charge will be $2.00; with an additional 50 cents charged for each additional 100 copies. Contact AMA Committee on Quackery, 535 N. Dearborn St., Chicago, Ill., 60610.

Meet on government

Physicians of the various medical specialty groups in Pennsylvania have been invited to attend a two and a half-day institute on government planned by the Pennsylvania Psychiatric Society. It opens Friday evening, March 29, and concludes at noon on Sunday, March 31, at the Host Farm in Lancaster.

With an ever-increasing amount of legislation which directly affects the private practice of medicine, the Pennsylvania Psychiatric Society and the Pennsylvania Medical Society (sponsors of the program) feel that it is imperative for physicians to learn more about how the legislative and executive branches of the government operate.

Developing communication and understanding how legislation is shaped are conference goals. Discussion of substantive issues and particular interests will be avoided in order to concentrate on establishing general avenues of communication and to explain methods of working with the legislators in whose hands the future practice of private medicine largely rests.

For registration forms, contact Donald N. McCoy, 20 Erford Rd., Lemoyne, Pa. 17043. A grant from Smith, Kline and French Laboratories is underwriting a portion of the conference expenses.

PENNSYLVANIA MEDICINE editorials

The case for the indian fruit-eating bat

Drug advertisements are an integral part of almost every medical journal. Many of them are eyecatching and imaginative. Others consist of several consecutive pages of fine print, similar to book club membership contracts, imparting product information. Unless you were especially interested in a particular drug, you would certainly be more likely to pause and read an advertisement presented by an intriguing picture than one that is not. Be that as it may, drug advertisements have recently come under fire (allegedly for sexism) primarily because of illustrations.

What, exactly, is meant by this accusation? Sexism may be defined as emphasis upon sex—in this case, one sex, the female. It has been charged that drug advertisements predominantly feature women as patients and less commonly males as patients. Further, it has been argued that women are prominently depicted as patients in advertisements dealing with drugs used in the treatment of anxiety and depression. If this premise is followed to its rational conclusion, it tends to indicate psychological inferiority. Women need drugs to keep their spirits up; men do not. Conversely, then, it perpetuates the myth of male superiority.

Based upon the foregoing, women's liberationists would indeed have proof of male chauvinism. The fortunate or unfortunate fact, depending on the point of view, is that the preliminary assumption is false. Women do not appear more commonly in drug illustrations. A random survey of current medical periodicals reveals no ground for the accusation. The closest possible substantiation of the claim is in drug advertising in a nationally circulated psychiatry journal which features about 50 percent female illustration. PENNSYLVANIA MEDICINE and JAMA, two journals that most physicians in the state receive, carry nothing that could be judged offensive.

Moreover, it is interesting to speculate upon the effect the picture accompanying a drug advertisement has on the physician's prescribing habits. It is very likely that it has no effect at all. Physicians treat each patient—man, woman, or child—as an individual with basic human and personal needs. It is unlikely that a physician's judgement of what he feels is in the best interest of his patient will be influenced, either consciously or unconsciously, by any outside factor, least of all by something so far removed from the case as a picture in a drug advertisement.

Drug illustrations serve a purpose. They attract attention. How else could the Indian fruit-eating bat depicted in the vitamin C advertisement be explained?

David A. Smith, M.D.
Medical Editor

PENNSYLVANIA MEDICINE correspondence

Judging professional competence

To the editor:

I just read your article, "Ways to Judge Competence," in the January issue of PENNSYLVANIA MEDICINE.

After ten years of employment with the Welfare Department in what amounts to a group practice, I'm really not enchanted much by the concept of the medical audit as a way to assure professional competence. I think the concept presupposes incompetence, rather than the reverse, and clearly reflects the authoritarian notions that physicians have toward patients and which some now wish to impose on one another.

I'm much more interested in your thought that perhaps the methods of medical practice, in a group for instance, have certain implications for competent professional care. Don't you think that the eventual gathering of physicians into forms of shared practice is going to resolve this issue substantially without inviting the imposition of a premature bureaucratic policing system?

William C. Ryan, M.D., Trustee, Eleventh District
Somerset

Case for examiner system

Director of Governmental Relations
Pennsylvania Medical Society

As you probably know, nearly 100 cities and counties in Pennsylvania have jumped into action to take advantage of the new era of local home rule, and have created Charter Commissions which are at work preparing new charters for submission to referendum in their respective bailiwicks within the next year or two. In our model medicolegal system pamphlet, we proposed creation of a state commission of appropriate existing officers who would combine to select a state medical examiner of appropriate medical qualifications who would, in turn, appoint medical examiners in each of the counties, arrange laboratory services, and provide technical supervision.

In Pennsylvania, the opportunities for modernization of this service come from the opposite end. Individual counties in the course of adopting county charters will meet the question of what to do with the elective county coroners; of course some of them will leave the office on the elective list to be selected on party tickets, and without medical qualifications. It would be inappropriate for us to try to reach all

those County Charter Commissions from New York, but we have some information to put at your disposal so that you can undertake it if you will. The first step in modernizing the function is to get it out of politics and into medical hands selected by appointment, and in many of the states this has been done, county by county, without any technical organization at the state capitol. After the function falls into the hands of medical men, they find that they need the rest of the model system. They then get aid on an informal basis from the coroners of the larger counties and from appropriate state authorities.

There is now at work a County Government Study Commission in the following counties: Allegheny, Bucks, Chester, Delaware, Lackawanna, Luzerne, Mercer, Montgomery, York, and Union.

In our ever changing manuscript entitled "Best States For a Murder", we estimate Pennsylvania as reposing the coroner function in elective county coroners covering 85 percent of the population, giving credit for a modern service to Philadelphia and Allegheny Counties. In some states the switch by a few counties to medical examiners has been followed swiftly by others, until coverage has become complete within a few years.

Richard S. Childs
Honorary Chairman, Executive Committee
National Municipal League

PENNSYLVANIA MEDICINE practice management

Phase IV with us in final form

LEIF C. BECK, LL.B.
Bala Cynwyd

The proposed new (Phase IV) regulations involving medical and dental fees referred to in my January article in Pennsylvania Medicine have finally been adopted by the Cost of Living Council. These rules give a little more leeway to the doctors than did the old rules regarding fee increases, but they continue to be complex and often rather confusing.

An important item to stress with regard to these new regulations is that no fees should be increased until and unless a doctor has discussed them with an appropriate advisor. I urge this in recognition of the fact that a number of physicians have been reviewed as to fee increases, and I do not believe any doctor would want the problems, bad publicity, or possible violation that would arise if he were found to have raised his fees illegally.

The new regulations require the preparation of a somewhat different type of fee schedule than in the past. This fee schedule should contain the following four columns:

1. **Fee Schedule of December 28, 1973**
2. **Any fee changes after that date**
3. **The date of any such changes**
4. **The "aggregate weight" of any fee change**

Perhaps the following sample fee schedule would be of some help as an illustration:

Doctors X, Y and Z
Schedule of Fees

Service Provided	Dec. 28, 1973 Fee	Fee Adjustments	Date of Adjustments	Aggregate Weight
Initial Office Visit	$25			
Electrocardiograms	15	$16	1/10/74	8 percent
Office Visit (Routine)	10			

The regulations further state that a copy of your fee schedule should promptly be furnished or mailed to any third party payor or Cost of Living Council representative upon request. This will be an extremely annoying requirement to any doctor, but you should be aware of the regulation's existence and have handy a fee schedule that may be duplicated and furnished to anyone upon request.

Finally, the rules also require posting of a sign indicating that your fee schedule is available at your office. The Pennsylvania Medical Society has printed a sign that could be used (see the January issue of Pennsylvania Medicine). The sign, posted at some spot in or around your reception area, should read:

> "In compliance with the Cost of Living Council Regulations a schedule of fees is available upon request".

This sign could be a small card, perhaps 4" x 7", and the wording could be typed on it.

If this information either frustrates or annoys you, let me assure you that I feel the same way. Nevertheless, the Cost of Living Council does have legal authority. Doctors should be aware of these rules.

Write or call for your sign *now*. Reprints are still available.

The Editors

Mr. Beck is President of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes... yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol C-III SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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acute gonorrhea*

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit...

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin®

2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

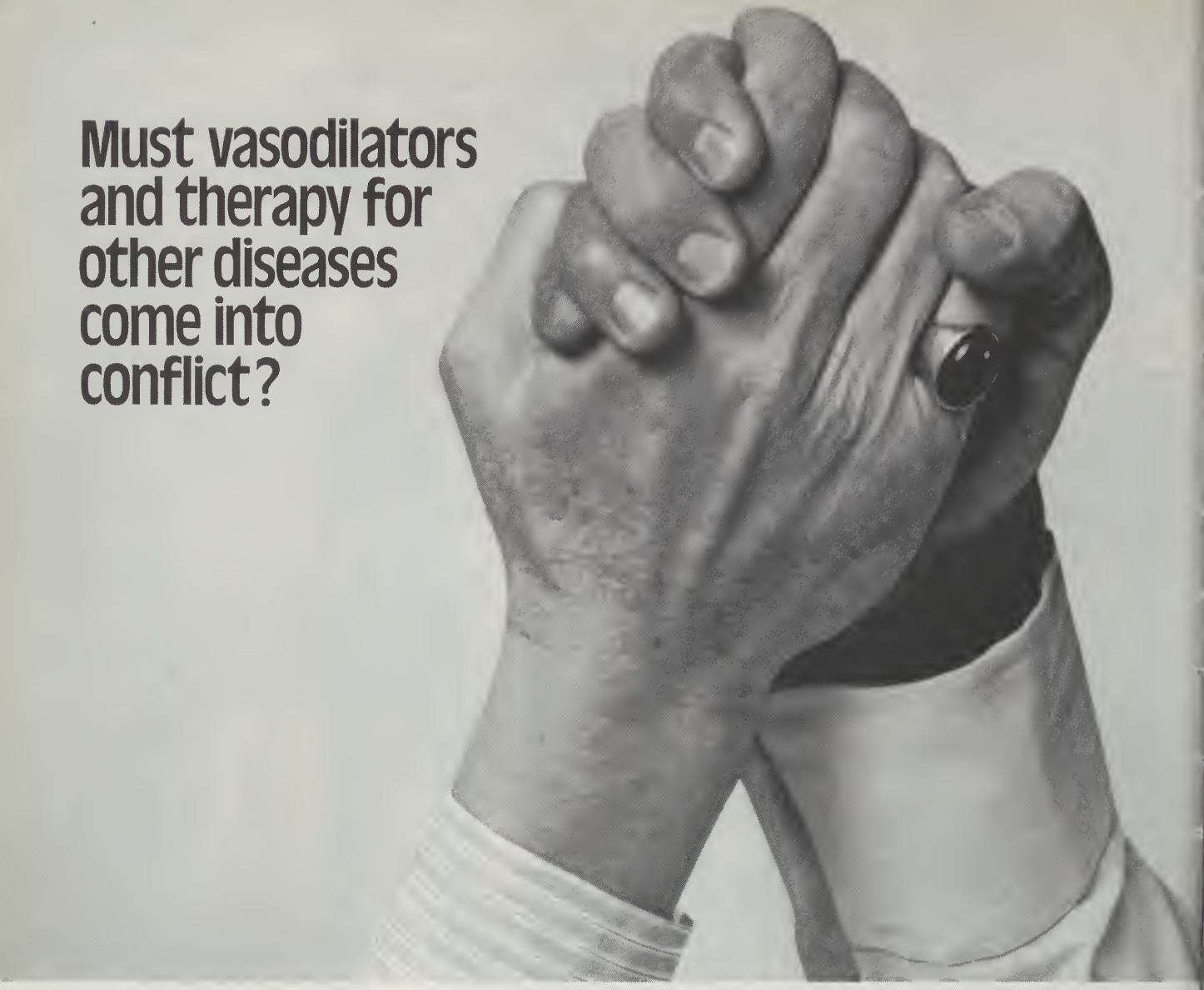
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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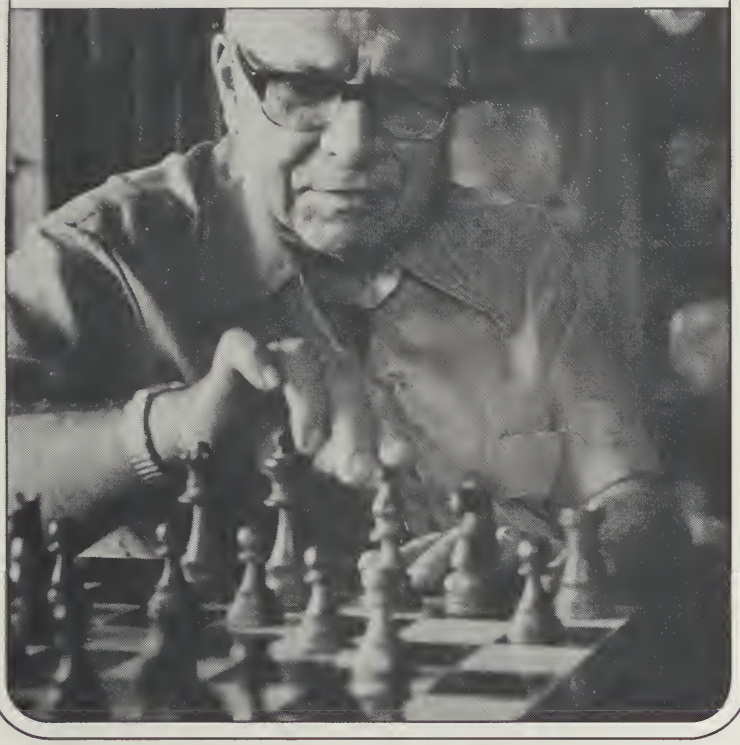
APATHY • IRRITABILITY FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

CEREBRO-NICIN® double-blind study* shows how some senile symptoms can be treated. Four times as many aging patients showed striking improvement.

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN **THE BROWN PHARMACEUTICAL CO.**
2500 W. 6th St., Los Angeles, Calif. 90057

*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Sherman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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Professional Protection

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Since 1899

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FORT WAYNE, INDIANA

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D. R. Lowe, L. R. Wilson, Jr., S. B. Elston, Jr., R. J. Nolen, Jr., and G. A. Baack, Representatives
Suite 101, The Benson Manor, Jenkintown 19046 Telephone: (215) 887-6335

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Synthroid®
(sodium levothyroxine)

the smooth road to thyroid replacement therapy.

***Synthroid* is T_4.**
It provides your patients with what is needed for complete thyroid replacement therapy.

Free Tab-Minder sample packages available from Flint Professional Services Department.

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

It has been shown that *Synthroid* (T4) converts to T3 at the cellular level to supply metabolic needs. [1, 2]

1 *Synthroid* is T4.

2 Because T4 converts to T3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1, 2]

3 T4 hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U. S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

8 When stored properly, *Synthroid* has a longer shelf life than desiccated thyroids.

9 On a daily basis, *Synthroid* is cost competitive with other thyroid products.

The smooth road to thyroid replacement therapy.

Synthroid®
(sodium levothyroxine)

In most cases with side effects, a reduction of sage followed by a more gradual adjustment ward will result in a more accurate indication the patient's dosage requirements without the pearance of side effects.

sage and Administration: The activity of 0.1 mg. SYNTHROID (sodium levothyroxine) BLET is equivalent to approximately one grain yroid, U.S.P. Administer SYNTHROID tablets a single daily dose. In hypothyroidism with- t myxedema, the usual initial adult dose is 1 mg. daily, and may be increased by 0.1 mg. ery 30 days until proper metabolic balance is tained. Clinical evaluation should be made onthly and PBI measurements about every 90 ys. Final maintenance dosage will usually nge from 0.2-0.4 mg. daily. In adult myxedema, arting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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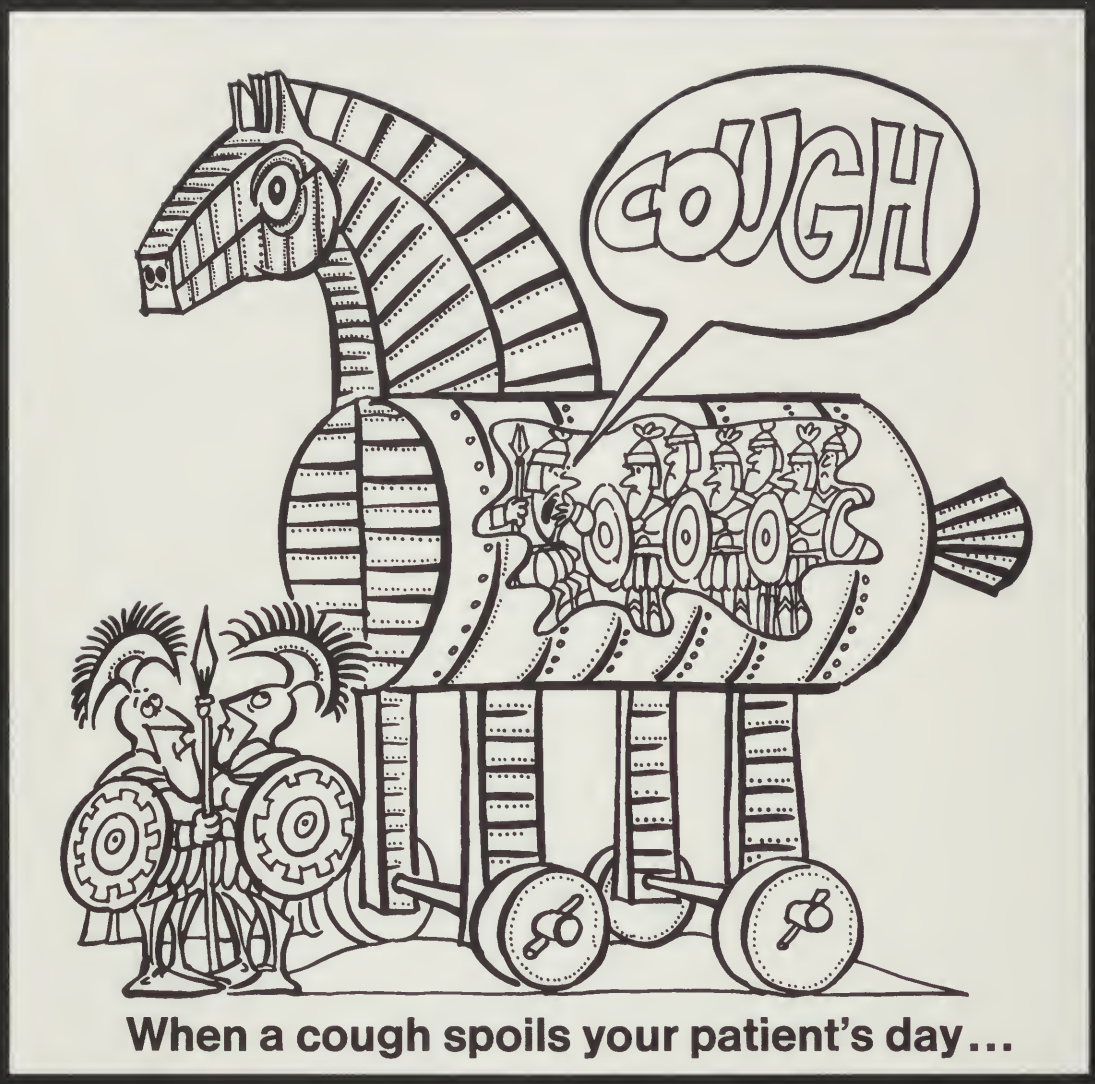

When a cough spoils your patient's day...

Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

When an antitussive is also desired, the same formulation plus 10 mg. codeine phosphate is available as **Triaminic Expectorant with Codeine.** (A Schedule V Controlled Substance.)

The Adult Expectorant that is great for kids, too.

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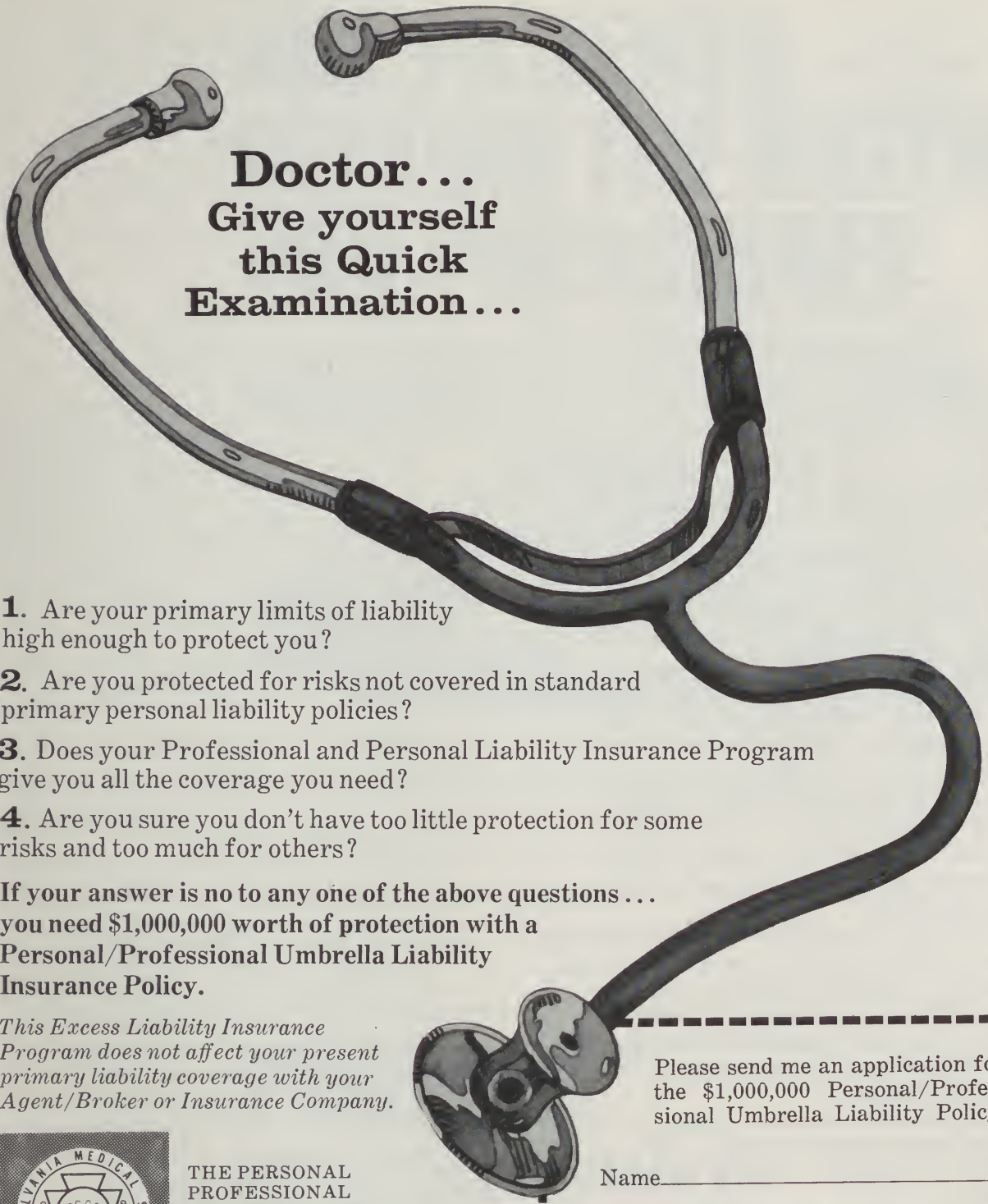
BO–SB



Doctor...
Give yourself this Quick Examination...

1. Are your primary limits of liability high enough to protect you?

2. Are you protected for risks not covered in standard primary personal liability policies?

3. Does your Professional and Personal Liability Insurance Program give you all the coverage you need?

4. Are you sure you don't have too little protection for some risks and too much for others?

If your answer is no to any one of the above questions... you need $1,000,000 worth of protection with a Personal/Professional Umbrella Liability Insurance Policy.

This Excess Liability Insurance Program does not affect your present primary liability coverage with your Agent/Broker or Insurance Company.

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Union Bank Building, Pittsburgh, PA. 15222

Please send me an application for the $1,000,000 Personal/Professional Umbrella Liability Policy.

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Current Concepts of Lower Limb and Spinal Orthotics as Related to Patient Evaluation and Therapeutic Training
Friday, April 19 and Saturday, April 20, 1974
Temple University
Health Sciences Center
Department of Rehabilitation Medicine and Rehabilitation Research and Training Center

Location of course and accommodations: Holiday Inn, City Line Avenue, Route One and City Line Avenue, Route One and I-76 (Schuylkill Expressway), Philadelphia, Pennsylvania, 19131.

A comprehensive two-day symposium with a multidisciplinary approach on normal and pathological gait and spinal dynamics, current and advanced techniques of therapeutic planning, orthotic prescriptions and components. New development demonstrations and presentation of fabrications of spinal, hip, knee, ankle, foot orthosis with biomechanical and kinesiological implications. Guest faculty consisting of nationally recognized authorities.

Course Credits: Applied for: Pennsylvania Medical Society, AMA, and American Academy of Family Physicians Registration limited to 200 - physicians: $120.00; registered therapists, orthotists, counselors, etc.: $90.00; residents, interns, and students: $60.00

Overnight accommodations available - Luncheons included in registration fee

Double Occupancy: $23.50 (meals not included)

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3400 North Broad Street
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PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

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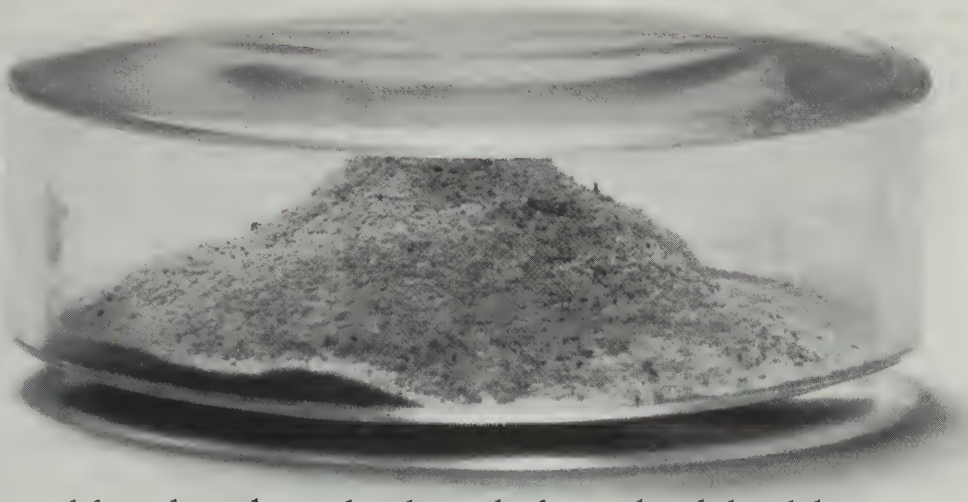
IN NATURAL THYROID THERAPY:

ARE PATIENTS GETTING THE POTENCY YOU PRESCRIBE?



Unlike U.S.P. desiccated thyroid, Proloid®(thyroglobulin) offers the assurance of constant potency.

To begin with, Proloid is uniquely purified. The thyroglobulin extracted from hog thyroid is devoid of any glandular debris.

Then, Proloid is chemically and biologically assayed to assure consistent metabolic activity from batch to batch. The T_4 and T_3 content of every dose is blended for optimal thyroid replacement.

Important, too, is the fact that Proloid is invariably "fresh" when your patients take it. Under proper storage conditions, its potency will not diminish for at least four years.

All of which adds up to this: the potency of Proloid is constant...for more consistent results.

PROLOID®
(thyroglobulin)

natural thyroid therapy that leaves nothing to chance

PENNSYLVANIA MEDICINE

M.D.s in the news

PAUL M. LEWIS, M.D., Pittsburgh, has been elected president of the American Association of Health Data Systems. He is executive director of the Hospital Utilization Project of Pennsylvania.

MICHAEL ISRAEL, M.D., assistant professor of pathology at Pennsylvania State University School of Medicine, Milton S. Hershey Medical Center, has been elected treasurer of the Pennsylvania Blood Bank.

The National Pituitary Agency has honored MANUEL A. BERGNES, M.D., with presentation of a nine-year service appreciation certificate. Dr. Bergnes is a pathologist at Sacred Heart Hospital, Norristown.

A dinner was given in Weatherly recently honoring CHARLES W. POTTER, M.D., health officer and medical advisor to the Weatherly Board of Health, in recognition of his twenty-five years of service to his community.

HARVEY LYONS, M.D., assistant professor of medicine at Hahnemann Medical College and Hospital, Philadelphia, and assistant director of nephrology at Philadelphia General Hospital, spoke on clinical problems of acid base metabolism at Harrisburg Hospital recently.

BENJAMIN GOULEY, M.D., of Jenkintown, was honored by the Albert Einstein Medical Center's Northern Division by having a visiting professorship instituted in his name on the occasion of his seventy-fifth birthday celebration. Dr. Gouley was chairman of the division of medicine at Einstein for eleven years.

GEORGE A. HAHN, M.D., past president of the Philadelphia Medical Society, has been elected vice president of the American Association of Obstetricians and Gynecologists.

Lancaster's first eye specialist, HARRY C. FULTON, M.D., has retired after fifty-eight years of medical service. He is a fellow of the Pennsylvania Academy and the American College of Ophthalmology and Otolaryngology, the American College of Surgeons, and a diplomate of the American Board of Ophthalmology. He is a past president of the Lancaster County and City Medical Society.

MARK M. RAVITCH, M.D., surgeon-in-chief at Montefiore Hospital and professor of surgery at the University of Pittsburgh School of Medicine, has been appointed to the Clinical Research Advisory Committee of the National Foundation of the March of Dimes.

DANIEL LIEBERMAN, M.D., has been elected president of the Philadelphia Psychiatric Society. He is professor and associate chairman of the department of psychiatry and human behavior at Jefferson Medical College, Thomas Jefferson University, and director of the Jefferson Community Mental Health/Mental Retardation Center.

DR. LIEBERMAN

DR. SAVACOOL

J. WOODROW SAVACOOL, M.D., clinical associate professor of medicine at Jefferson Medical College, Thomas Jefferson University, has been appointed director of the Student Employee Health Service at Thomas Jefferson Hospital. He is a representative of the Pennsylvania Thoracic Society to the American Thoracic Society, a fellow of the American College of Physicians, and a past president of the Pennsylvania Chapter of the American College of Chest Physicians.

JOHN R. SPANNUTH, M.D., is the first recipient of the "Service Above Self" award presented by the Reading Rotary Club for community service and professional excellence.

A twenty-seven-year-old Mount Carmel physician believes strongly in the benefits of exercise in preserving good health. JOSEPH M. SIENKIEWICZ, M.D., makes his house calls by bicycle as an example to his patients. Half a dozen such calls a day are about average, although he does limit such calls to a radius of four miles from his office in the interest of time.

ROBERT P. MYERS, M.D., Bethlehem, has been appointed consultant in urological surgery at the Mayo Clinic, Rochester, Minnesota.

ROBERT R. CONTE, M.D., has been installed as president of the Latrobe Academy of Medicine.

RAYMOND W. BOROTA, Pittsburgh, has been named acting chief of otolaryngology at the VA Hospital in Oakland. He was recently certified as a diplomate by the American Board of Otolaryngology.

R. BRIAN SMITH, M.D., Pittsburgh, has been named vice chairman of the department of anesthesiology for the University Health Center of Pittsburgh. BRUCE L. JOHNSON, M.D., has been appointed associate professor of pathology at the University of Pittsburgh School of Medicine. He also heads the ophthalmic pathology laboratory there.

The Frederick M. Jacob Physician Merit Award for service to the Allegheny County Medical Society was presented jointly to SAMUEL P. HARBISON, M.D., and C. WILLIAM WEISSER, M.D., both of Pittsburgh.

GEORGE L. JACKSON, M.D., director of nuclear medicine at Harrisburg Hospital, has been appointed general chairman for the Eastern Pennsylvania Regional Meeting of the American College of Physicians which will be held in November at Hershey.

DAVID A. SMITH, M.D., medical director of Polyclinic Hospital, Harrisburg, and medical editor of PENNSYLVANIA MEDICINE, has been installed as president of the Central Pennsylvania Academy of Medicine. ERNEST D. HELMICK, M.D., New Cumberland, is the new treasurer.

PAUL S. FRIEDMAN, M.D., Philadelphia radiologist, has been appointed to the National Advisory Health Council by Secretary of Health, Education, and Welfare Caspar W. Weinberger.

RALPH A. CARABASI, M.D., Bryn Mawr, is chairman of the Philadelphia Breast Cancer Task Force of the American Cancer Society. He is associate professor of clinical medicine at the Jefferson Medical School of Thomas Jefferson University.

Three members of the department of psychiatry at Medical College of Pennsylvania have been selected to head psychiatric organizations. ROBERT STEPPACHER, M.D., assistant professor of psychiatry, has been installed as president of the Eastern Pennsylvania Psychiatric Institute. LOUIS A. LEAFF, M.D., also assistant professor of psychiatry, has become president of the Delaware Valley Association of Directors of Psychiatric Residency Training Programs. SIDNEY WENGER, M.D., clinical professor of psychiatry, is the new medical director of the Philadelphia Psychiatric Center.

JOSEPH B. BITTENBENDER, M.D., Mechanicsburg, was awarded the William H. Seibert Fund Award for outstanding teaching in neurology by the Central Pennsylvania Academy of Medicine recently.

ROBERT YANNACCONE, M.D., Watsontown, medical director of White Deer Run, an Allenwood rehabilitation center, has been presented with a special plaque in recognition of his success with drug and alcohol abusers. Dr. Yannaccone is particularly active in securing employment for rehabilitated graduates of the center.

Two Philadelphia physicians have been elected members of the Board of Governors of the American College of Surgeons. They are WILLIAM C. FRAYER, M.D., and JOHN TEMPLETON, M.D. Dr. Templeton is president of the Philadelphia County Medical Society.

New Officers

Jefferson County Medical Society
W.G. Lundgren, M.D., Du Bois, president
Rodger Haglund, M.D., Du Bois, president elect
Clifford Lull, M.D., Du Bois, secretary-treasurer

Delaware County Medical Society
John L. Kelly, M.D., Media, president
Furman T. Kepler, M.D., Havertown, president elect
Hunter S. Neal, M.D., Philadelphia, vice president
F. Peter Kohler, M.D., Bryn Mawr, secretary
Samuel D. Allen, M.D., Rosemont, treasurer

Lackawanna County Medical Society
Joseph N. Demko, M.D., Dunmore, president
Edward J. Notari, M.D., Dunmore, president elect
Stanley W. Boland, M.D., Clarks Green, vice president
Charles J. Bannon, M.D., Scranton, vice president
Dominick A. Crucianni, Jr., M.D., Scranton, secretary-treasurer

Bradford County Medical Society
J. Alan Reid, M.D., Athens, president
Paul C. Royce, M.D., Sayre, vice president
Richard E. Shelling, M.D., Sayre, treasurer
William A. Steinbach, M.D., Sayre, secretary

Dauphin County Medical Society
Claude E. Nichols, Jr., M.D., Harrisburg, president
Milton Friedlander, M.D., Camp Hill, president elect
Paul F. Kase, M.D., Harrisburg, first vice president
Bernard Margolis, M.D., Harrisburg, second vice president
G. Winfield Yarnall, M.D., Harrisburg, secretary-treasurer

Lancaster City and County Medical Society
William G. Ridgway, M.D., Akron, president
Roland A. Loeb, M.D., Lancaster, president elect
James F. Young, M.D., Lancaster, vice president
F. Barrie, Moberg, M.D., Lancaster, secretary-treasurer

PENNSYLVANIA MEDICINE

book review

Allergy Management in Clinical Practice. by Louis Tuft. St. Louis, C.V. Mosby, Co., 1973. 426 pages, illustrated. $29.75.

With a few notable exceptions, most available books on allergy deal with the pediatric age group or with a specific entity such as insect or food hypersensitivity. Happily, this book provides a concise compendium of allergic phenomenon.

The author assumes nothing and the initial chapters are introductory in nature, covering basic terminology and principles. Considerable space is given to diagnostic methods which are of prime importance in dealing with allergies. The author devotes several pages to the proper history and physical examination of the allergic patient, for clues may be found here which aid in detecting the causative agent. Various diagnostic tests are reviewed and case reports are included as illustrative material.

Having established a solid foundation and vocabulary with which to work, the author devotes the remainder of the book to the features and management of allergic conditions. Material covered includes such diverse topics as drug reactions, asthma, neurologic allergy, allergy to fungi, and allergic dermatoses. Each of these chapters contains case reports and drugs of choice (listed by trade name) for the condition described. Drug dosages are also recommended.

Most medical books on the market today are profusely illustrated. References usually appear either at the end of each chapter or at the end of the book. This manual contains the necessary illustrations and charts to clarify the text. It is footnoted, thereby eliminating the necessity of searching for references. General references are included at the end of the book, but less than one page is required to list them. Indexing is adequate.

Most physicians see some type of allergic phenomena in everyday practice, thus demonstrating a need for a book dedicated to the management of these patients. *Allergy Management in Clinical Practice* would be a useful reference work for any practicing physician.

David A. Smith, M.D.
Medical Editor

Foundation introduces review program—CHAMP explained

MARY L. UEHLEIN
Managing Editor

Hospital officials in Pennsylvania received early in February an outline of a utilization review program for hospitalizations—the result of two years of research and development by the Pennsylvania Medical Care Foundation, Larry R. Fosselman, executive director, has announced. State Society and hospital medical staff officers were included in the mailing.

The Pennsylvania Medical Society mandated the Foundation to develop a program to assure effective utilization of hospital facilities consistent with recognized standards of quality care as an alternative to the impending imposition of government controlled review of hospital stays paid for under medicare and medicaid. The result—the Certified Hospital Admissions Monitoring Program (CHAMP)—calls for locally made decisions, involves physician judgment, and makes possible timely payments for hospital stays.

Building on existing resources within the hospitals, CHAMP relies on physician committees in local areas to make decisions on need for hospitalization and length of stay, including requests for extensions if such are made by the attending physician.

Review Starts on Day One

CHAMP functions on the basis of concurrent review from the first day of hospitalization, but also offers a method for pre-admission certification if hospitals feel a need to implement such a system. Fosselman said:

"The advantage offered by CHAMP is that decisions on length of stay are made at the local hospital rather than at a central location, and are made by physicians rather than by government or third party carrier employees. CHAMP fits into the design for the Professional Standard Review Organization (PSRO) plan for medicare and medicaid cases, which specifically calls for physician involvement on the local level to assure proper utilization and quality of care—it is, in effect, concurrent review of utilization and of length of stay based on recognized standards. CHAMP offers Pennyslvania hospitals and physicians a viable method for implementing the PSRO law because it provides an objective and effective means for assuring that decisions regarding the quality and necessity of medical care are based on professionally recognized standards, and because it utilizes review committees already functioning in hospitals and established criteria which have been tested and found satisfactory."

Philosophy Explained

The system, Fosselman explained, is based on a philosophy developed from the answers to two questions: What is the best action to take in the interest of the patient?—and—What is the most practical method to accomplish it?

While the primary reason for the mailing to hospital administrators, medical staff presidents, and utilization review chairmen is to prepare for the implementation of PSRO, a second reason is to present an alternative to the program of the Department of Public Welfare (DPW) now being operated in hospitals in Allegheny and Philadelphia Counties. This program, Pre-Discharge Utilization Review (PDUR), requires confirmation of length of stay for medical assistance patients within forty-eight hours following admission, from DPW employees in Harrisburg, and approval for extension of stay, also from Harrisburg, based on a request made during the final forty-eight hours of the originally approved length of stay.

The publication of proposed federal rules covering hospitalization of medicare and medicard patients by the Department of Health, Education, and Welfare, preempting, it would seem, the implementation of PSRO, also prompted the Foundation to move quickly to expose its proposal to hospitals, as well as to comment on the proposed rules. The Foundation's comments on the proposed rules appear elsewhere in this issue.

How CHAMP Works

CHAMP works simply. It adheres closely to admissions procedures now in use.

If, after evaluating the patient, the physician decides hospitalization is medically indicated, he contacts the hospital admissions office in the usual fashion to reserve a bed and determine the admission date. Urgent and emergency admissions are handled according to existing procedures at each hospital.

The CHAMP certification form (shown here in sample form) requires the usual information, as well as an indication of any outpatient tests performed. If the utilization coordinator finds that the diagnosis and prospective treatment are consistent, the number of days for hospitalization will be certified for reimbursement. Keep in mind that this procedure will fill the requirements of the PSRO law and does what the Department of Welfare's PDUR program does, except that it is done locally and with physician involvement. If the utilization coordinator finds that the indications for admission do not conform to established criteria, the certification form is forwarded to the chairman of the utilization committee or his representative for review. If the chairman does not find cause for approval of the admission the case is discussed with the attending physician. The attending physician may appeal the case to the hospital's utilization review committee for a final decision.

As in the case of approval of admissions, the utilization coordinator may approve extensions of stay requested by the physician, but *may not* disapprove. Here again the request for extension must be forwarded to the chairman of the utilization review committee for action.

What the Coordinator Does

The utilization coordinator may be a registered nurse, medical records librarian, or other individual with special training in medical terminology and application of medical care criteria. The coordinator acts under the direction of the physician chairman of the utilization committee and handles day to day administrative responsibilities. The coordinator also is responsible for assisting the hospital's social services department in discharge planning activities, including removal to another level of care when indicated.

Follow-Up Activities

The hospital utilization committee not only reviews appeals on admissions and extensions of length of stay, but it also evaluates retrospectively the performance of the coordinator and the information tabulated from the medical record abstract and certification form and will report to the local PSRO when it is established.

The Pennsylvania Medical Care Foundation has available a guide to hospitals, "The CHAMP Procedural Manual," which is available from: Larry R. Fosselman, Executive Director, Pennsylvania Medical Care Foundation, 20 Erford Rd., Lemoyne, Pa. 17043.

CERTIFICATION FORM DRAFT 8/28/73

PENNSYLVANIA MEDICAL CARE FOUNDATION **Certified Hospital Admission Monitoring Project (CHAMP)**

PATIENT INFORMATION		HOSPITAL INFORMATION	
NAME (Last, First, M.I.)		NAME	
SOCIAL SECURITY NO.		NUMBER	
SEX		UR COORDINATOR NUMBER	
MEDICAL RECORD NUMBER			

ADMISSION INFORMATION

DATE OF REQUEST	TYPE OF ADMISSION	REFERRING PHYSICIAN		NUMBER
SCHEDULED ADMISSION DATE	Elective ☐	ADMITTING PHYSICIAN		NUMBER
SCHEDULED SURGERY DATE	Urgent ☐			
ACTUAL DATE OF ADMISSIONS	Emergency ☐	ATTENDING PHYSICIAN		NUMBER

ADMITTING DIAGNOSIS(ES) Confirmed ☐ Provisional ☐	ICDA-8 CODE	NUMBER OF DAYS CERTIFIED	
		Provisional Dx	Confirmed Dx
Primary			
Secondary			

PROPOSED SURGICAL PROCEDURE(S)			
PRINCIPAL			

PRE-ADMISSION TEST(S)	INDICATION(S) FOR ADMISSION (Reason treatment cannot be provided as out-patient)
NO ☐ YES ☐	
If Yes: Office ☐ Hospital ☐ Other ☐	

EXTENSION INFORMATION

REASON(S) FOR EXTENSION	REVIEW DECISION								
	Date of Request	Coord	Phy. Advisor		UR Com		Date of Decision	Days Requested	Day Certified
		Yes	Yes	No	Yes	No			

Physician Advisor	Signature	I.D. Number		TOTAL CERTIFIED DAYS (Admission & Extension)	
PHYSICIAN APPEAL	Admission ☐ Extension ☐	Attending Physician Signature (if appealing)			Date

DISCHARGE INFORMATION

FINAL DIAGNOSIS(ES)-if different than admitting	ICDA-8 CODE	DATE OF DISCHARGE	
PRIMARY			
SECONDARY		DISCHARGE PLANS-PATIENT DISPOSITION	

DATE OF SURGERY	SURGICAL PROCEDURE(S)		
	PRINCIPAL		

Consultant offers possibility

Try this for COLC approval of DPW fee increases

LEIF C. BECK, LL.B.
Bala Cynwyd

Leif Beck, president of Management Consulting for Professionals, Bala Cynwyd, who writes regularly for Pennsylvania Medicine, offers these possibilities for physicians who have been deprived of fee increases for the care of medicaid patients by discriminatory Phase IV rules. Individual exemptions are required, and physicians should apply for them. But the author, knowing the situation, says, "I won't bet on it."

As described in the January issue of PENNSYLVANIA MEDICINE, the Society's request for a blanket exemption to accept increased fees paid for by the Department of Public Welfare (DPW) for office and home visits was rejected by the Cost of Living Council (COLC). Permission had been sought to increase office visit fees from $4 to $6 and house call fees from $5 to $7. In denying the blanket increase for *all* physicians, however, the council's health administrator left open the opportunity for any physician to seek an exemption on his own.

Many Society members have thus asked how they should go about seeking permission to increase their medicaid fees to the amounts newly authorized by the Department of Public Welfare. This article gives my suggestions and observations based upon the Phase IV price control rules adopted in January.

First of all, any physician may increase his fees for DPW work by $1 without seeking official Cost of Living Council approval provided the increase falls within the Phase IV requirements allowing certain annual increases. These requirements have been described in my article which appeared on page 17 of the January issue of PENNSYLVANIA MEDICINE (Phase IV Rules—Heaven Help Us), and any physician should refer to it and consult with his advisers to determine if a $1 increase is justified.

'In denying the blanket increase for all physicians . . . the council's health administrator left open the opportunity for any physician to seek such increases on his own.'

Since no fee under $10 may be increased more than $1 without COLC approval, however, the opportunity to take full advantage of DPW's new payment schedule is far more difficult. An increase of the second dollar may not legally be made by any physician unless he has requested and received an exception from the Cost of Living Council.

'An increase of the second dollar may not legally be made by any physician unless he has requested and received an exception from the Cost of Living Council.'

The council's letter denying the blanket exemption specifically suggested that "where a hardship exists, the physician apply for an exception." It also suggested that the Society assist the physician in those cases.

"Hardship" Circumstances

Although each physician should insert into his request those facts which would establish the "hardship" circumstances applying to his individual situation, there are some arguments which might be common to all such requests. Accordingly, the form of letter appearing at the end of this article might be helpful to Pennsylvania Medical Society members.

The new Phase IV rules specify a number of factors the council will specifically consider in reviewing a request for an exception. They include the following: (1) whether the present fees are substantially unrepresentative of the [doctor's or group's] current practice; (2) whether a significant imbalance exists between the costs and a [specific fee]; and (3) whether a practitioner is contemplating a move to an underserved area where medical care is badly needed. There are other factors which individual members might also find appropriate, but the three cited above seem most generally applicable.

If a member has not received COLC approval or denial within sixty days from the date his request is filed, the regulations permit the requested fee increase to go into effect as *"provisionally approved."* In such a case, the new fee level may be charged until and unless the council thereafter notifies the applicant otherwise.

Although the council's letter invited applications for exception, and despite the regulations' special recital of factors to be considered, I am very skeptical. The Cost of Living Council has been uniformly unsympathetic to medi-

cal practitioners' requests in both the price and wage control areas. I see no particular likelihood of a changed attitude. I hope some members will prove me wrong and will be granted exceptions for "hardship" situations, for I believe the DPW increase is important to improving medical care for the needy, but I won't bet on it.

Suggested Form of Exception Request

Office of Health
Cost of Living Council
2000 M Street, N.W.
Washington, D.C. 20508

Re: Name, address, and employer
Identification number of applicant

Dear Sir:

The applicant is engaged in the practice of medicine. Pursuant to Section 150.739 of the Phase IV regulations governing fees charged by medical practitioners, an exception to those regulations is hereby requested.

Specifically, your approval is requested for the following fee increases:

(1) Office visit fees charged to and paid by the Pennsylvania Department of Public Welfare (DPW) from $5 to $6 (the present fee has been $4, but an increase to $5 has been determined under the regulations without need for an exemption). [If applicable.]

(2) House call fees charged to and paid by the Department of Public Welfare from $6 to $7 (the present fee has been $5, but an increase to $6 has been determined proper under the regulations without need for an exception). [If applicable.]

[Then recite individual facts relating to your practice, including: (a) the fee for these services to other than DPW; (b) the number of DPW charges during a representative year, whether they might be increased, etc.; (c) whether the increases will increase the practice's "revenue margin" and whether they will increase the gross income more than 4 percent—the other two Phase IV tests.]

We understand that the Pennsylvania Department of Public Welfare has obtained federal agency approval to increase payments to the requested levels under the Medical Assistance Program. Such approval has apparently been granted in recognition that DPW payments have been unrealistically low and have failed to act as incentives for rendering of services to needy patients. Without reasonable comparability between fees charged to paying patients and those charged to welfare recipients, a single level of quality care for all U.S. citizens (rich or poor) will be difficult to achieve. While the applicant strives to provide equal care to all, we recognize the economic disincentives as to DPW patients.

Your regulations permit exceptions to be granted "for the purpose of preventing or correcting a serious hardship or gross inequity," Section 150.739(a). We submit that it is grossly inequitable for our regular office visit and house call fees to be so severely discounted that they might be below what the state itself is willing to pay—and far below our usual fees. We further submit that the inequity would apply not only to our own practice, but to the welfare recipients themselves, for whom highest quality care would not be economically encouraged.

The exception is specifically requested under your regulation, Section 150.739 (a)(2)(i), in that the present fees are "substantially unrepresentative of the petitioner's practice." Our normal fees for office visits and house calls are $— and $— respectively, in which case even the requested fees of $6 and $7 for DPW patients will clearly be unrepresentative. The lesser fees for such DPW work had existed only because of the Pennsylvania DPW payment restrictions (which are now increased) and not because they had been representative of our practice.

Reference is also made to your regulation, Section 150.739 (a)(2)(iii), reciting as a factor "whether the medical practitioner is contemplating a move to an underserved area where medical care is badly needed." Although not contemplating relocation, the economic incentive to seek out and serve more than the present number of DPW patients (about — percent of our total) would be served by your granting this exception.

Respectfully submitted,

Dr. Marshall answers questions

(Continued from page 9)

I can see in the next few years the possibility that the legislation will be challenged. In my opinion the major thrust for repeal will not come from the small group of Congressmen who are pushing for repeal, apparently without being aware of the more objectionable sections of the law which the PSRO section supercedes. It will come rather from groups of people who feel that delegation of authority to local physicians is not appropriate and that more control should be in the hands of the Social Security Administration, a single state agency, a federal commission on quality assurance, or the Office of Management and Budget.

Do our Congressmen from Pennsylvania understand the significance of PSRO legislation, its complexities, and the opportunity for either success or failure?

We have informed them of our point of view and expect to continue to do so.

What is their response?

Very supportive. They realize we have taken a strong stand for PSRO because it means that local physicians will be monitoring health care and public responsibility, even though this position is controversial. They understand that some of our problems with the federal and state government have been frustrating and time consuming. I hope their willingness to become more familiar with the specifics of our problems in implementing PSRO will lead to a more realistic assessment of the limitations of bureaucracy in solving local health care problems.

Voluntary program announced

Internists board announces recertification test

The American Board of Internal Medicine (ABIM) has announced an interim methodology for evaluating the continued abilities of practicing internists in the form of recertification examinations. The Board's long-range goal is assessment by performance, but it feels that until effective means of measuring clinical competence can be identified, individual Board certified internists may wish to enter this program of continuing medical education, self-assessment, and voluntary reexamination.

The primary purpose of the recently announced program is to assure improvement of the quality of care by certifying the continued competence of the internist at least six years after his initial certification and thereafter no more often than every subsequent six years.

The recertification process will (1) Provide a syllabus developed by the American College of Physicians covering significant advances during the past five years in internal medicine and its nine subspecialties; (2) Offer a self-assessment questionnaire as a prerequisite to taking the recertification exam; and (3) Hold recertification examinations of a multiple choice type pertinent to the material in the syllabus and the self-assessment program.

The recertification program is voluntary, and those deciding not to undertake it or those who are unsuccessful in taking it will not lose their certification.

The Board believes that ultimately assessment leading to certification of continued competence should focus on clinical competence rather than on the recall of knowledge in diverse subspecialty areas. However, an available method has not yet been perfected to allow a standardized adaptation of this approach. Peer Review is regarded as consistent with the concepts of accountability, education, and the improvement of care and clinical credentials.

The first recertification examination for diplomates certified in 1968 and before will be held Saturday, October 26, 1974. The preparatory syllabus was mailed in January, and the self-assessment questionnaire is due in July. Requests for further information regarding the program should be addressed to: The American College of Physicians, MKSAP III, P.O. Box 13646, Philadelphia, Pa. 19101.

Seminar on death, dying offered by foundation

A program sponsored by the Hospital Educational and Research Foundation on coping with death and the dying patient is slated for Monday, April 8, at the Penn Harris Motor Inn in Camp Hill.

The program's speaker, Elizabeth K. Ross, M.D., Flossmoor, Ill., identifies the need to continue support of the dying patient by developing concepts and techniques for treatment during the last stages of life.

Physicians, nurses, social workers, clergymen, other hospital personnel, and the interested public may register. Preregistration is required. The cost is $10 including luncheon or $6 without the luncheon ticket.

Contact Mary Ellen Mackert, Nursing Consultant, Hospital Educational and Research Foundation, P.O. Box 608, Camp Hill, Pa. 17011, for further information.

Two companies withdraw malpractice coverage

The St. Paul Insurance Co. is withdrawing completely from Pennsylvania with respect to physicians and surgeons classified for rating purposes in Classes Three, Four, and Five—classifications which include general practitioners performing major surgery; general surgeon specialists, including cardiac, thoracic, vascular, neurological, and plastic surgeons; ophthalmologists, proctologists; urologists; otolaryngologists; orthopedists, obstetrician-gynecologists; and anesthesiologists.

The Professional Liability Insurance Company of New York, underwriter of the malpractice insurance program sponsored by the Americal Urological Association, has been told by the Maryland Insurance Department to cease its operations in that state. Since Maryland is the home state of the Urological Association's program, members nationwide who are covered are already being notified that their coverage will not be renewed beyond the regular anniversary date.

State Society members affected by these developments are eligible for the Society sponsored professional liability insurance program. Write to the Council on Medical Service, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043, or see the announcement on page 3 of this issue.

Writing workshop scheduled

A medical writing workshop will be presented by the Delaware Valley Chapter of the American Medical Writers Association at the Philadelphia County Medical Society on March 23, 1974, from 9 a.m. to 5 p.m. Physicians, editors, medical students, residents, interns, and health care personnel are eligible to attend.

The program will feature physicians, medical editors, and hospital public relations executives.

Applicants may register by contacting Mrs. Edith Schwager, the association's president, at Hahnemann Medical College and Hospital, 230 N. Broad St., Philadelphia, Pa. 19102. The $35 fee includes a box lunch.

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PENNSYLVANIA MEDICINE special report

Retirement questions answered— relax with ease

ROBERT L. LAMB
Communications Division

When that day finally arrives when you lock the front door and head for Florida, you want to be sure you've taken care of all the little details which might slow down your escape. One of the first questions is:

How Long Shall I Keep My Patient Records?

You'll want to hold onto them for a while, at least, because they are an essential part of your defense in any malpractice action. Based on the Statute of Limitations in Pennsylvania, PMS Legal Counsel, Fred Speaker, recommends that office patient records be kept for an absolute minimum of six years;

and if space is available, for ten years. Certainly if you are in one of the high-risk surgical specialties, you will want to hold on to them as long as possible. As you know, if a missing sponge turns up even more than ten years later, the opportunity for suit exists.

Once you've set your policy, you can establish a system for periodic discard review. Bear in mind, however, that records of minors should be kept for a minimum of thirty-six months beyond their twenty-first birthday. A minor has the right to bring suit on his own when he has reached his majority.

If They are My Medical Records, Why Must I Honor Transfer Requests?

To determine who has a right to your office medical records, we have to split some hairs. Obviously both you and the patient have an interest in the medical record. If you ask who owns the piece of paper on which the record is written, the answer is "the physician." If you ask if the patient has a vested interest in the *information* contained in the record, the answer is "yes." How, then, can the best interests of the doctor and patient be served? When the physician has authorization from the patient, he may make the information contained in his records available to the patient's current physician.

How Can I Transfer the Medical Record and Still Protect Myself and Estate?

It's a problem, but it can be handled in a number of different ways. First, don't give the medical record to the patient. Get it directly into the hands of the new physician. The patient, according to medical ethics, is not entitled to have physical possession of his office medical record.

How you effect the transfer will depend on your own circumstances. Here are some possibilities: (1) Photocopy the record and send the duplicate; (2) Abstract the important parts; (3) Lend the record to the new physician with a request for return; (4) Have the new physician sign as custodian of the record and agree to make it available upon request by you or your estate, and have him return it to you rather than to transfer it to a third physician; (5) Call the new physician and work out the problem in a mutually satisfactory manner.

What are My Obligations in Notifying Patients of My Retirement?

When you retire, medical ethics require that you give patients sufficient notification so that they may find another doctor. This will vary by community. Since retirement is usually planned long in advance, you can determine the waiting time in your community for new patients. Add on a couple of weeks and accordingly, notify your patients of the dates when you will close the practice and the office. Tell patients to ask the new physician to get in touch with you if he feels that your records are important for adequate care. Most patients consider those medical records very important and begin calling the county and state medical societies if there is a problem in the transfer. Often these records determine a patient's eligibility for some insurance program.

How Long Must I Continue to Honor These Requests for Transfer?

There is no time limit on when a former patient may request transfer of information from his records. It may be helpful, however, to indicate in your retirement notice to patients a request to present their authorizations for transfer of this information by the closing date of the office.

The exact protocol for closing a practice is spelled out at the county society level. The AMA, however, recommends that patients and colleagues be advised. In some areas, a

simple announcement in the newspaper is used along with other means, such as correspondence.

If you plan to leave town, it would be helpful if you have made arrangements in the community on how to handle late requests for transfer of information from records. County medical societies, the hospital, PMS, attorneys, and banks are possibilities.

Is Selling Patients' Records Permitted?

According to AMA medical ethics, "A physician, retiring from practice, may not ethically sell his patients' records to another physician. His records have been developed during the physician - patient relationship. To *sell* records would tend to make patients subject to barter to the highest bidder."

There is the added problem of patient confidentiality. Section 9 of the Principles of Medical Ethics says that a physician may not reveal the confidences entrusted to him in the course of medical attendance without the patient's consent. This same restriction holds true for patients' records. "To transfer a patient's records without his consent would violate this confidence."

The obvious corollary is, "A physician may not ethically *purchase* such records from a retiring physician or from the estate of a deceased physician."

Can I Charge for Making Copies of Patients' Records?

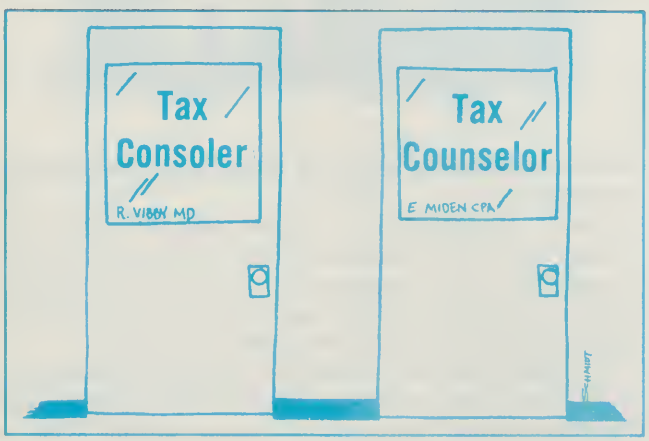
Custom varies widely. The best rule is to check your county medical society. Traditionally, transfer of records to the new physician was a free service provided by a retiring doctor, but now photocopying expenses can add up quickly, just when your income is about to drop. County societies can give advice on local custom.

Can I Use the Transfer of Records to Collect Old Bills?

The answer is, no. Medical ethics say: "The interest of the patient is paramount in the practice of medicine. Everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient." It would be improper and unethical to withhold information until an invoice is paid.

If I Can't Sell the Patient Records, What Can I Sell?

You can sell the physical assets of the practice—the fixtures, equipment, supplies, perhaps an office lease, and the goodwill of the practice. To do it you will certainly need a personal attorney. To help both you and the attorney, send for the book, "Sale or Disposition of a Medical Practice," prepared by the Office of the General Counsel of the American Medical Association. It can be obtained from the Communications Division, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.



To help you sell the practice, you can place an ad in the classified section of PENNSYLVANIA MEDICINE. For details, contact the managing editor.

Don't be surprised if the buyer wants to pay more for the physical assets and less for the goodwill. He can depreciate the physical assets. The buyer may want a clause in which you agree to assist him for a time or at least be available for consultation. Unless you already have your house in Florida, he may also want a "Covenant Not To Compete." Certainly it will be to both your and the buyer's advantage if patients can continue to come to the same office and dial the same telephone number.

How Do I Dispose of Narcotics And Other Dangerous Drugs?

At the time of retirement, you should write to your local Drug Enforcement Administration office (DEA) (formerly the Bureau of Narcotics and Dangerous Drugs) and request a copy of Form 41. Fill it in and return it to the Drug Enforcement Administration, either in person or by Registered Mail, along with all your narcotics and dangerous drugs. Your local DEA office can give you further information. In Central and Eastern Pennsylvania, write: Drug Enforcement Administration, 400 Market Street, Suite 1000, Philadelphia, Pa. 19106 (215) 597-9530. In Western Pennsylvania write: Drug Enforcement Administration, Federal Building, 1000 Liberty Avenue, Pittsburgh, Pa. 15222 (412) 644-3390.

Insurance—Do I Cancel or Not?

Fire, theft, and property liability policies can be canceled after the sale of the property has been completed; but you want to think twice about canceling your professional liability insurance. If there is a chance you might do some part-time work or consulting, you will need your malpractice insurance, but let your carrier know because you may be eligible for a lower rate. Whether you will continue to be eligible for the PMS endorsed program will depend upon whether or not you stay in Pennsylvania. In any event, keep old policies. The policy in force at the time the alleged malpractice incident occurred will cover you. Maintain workman's compensation insurance as long as you have employees.

What about Professional Organizations and Dues?

Notify all your professional organizations about the date of your retirement. Some, like the State Society, may have different categories for retired members, with reduced or no dues. The drawback here is that such categories usually take you out of the politics of the organization.

What about Final Details?

Contact your county medical society, your personal attorney, your insurance representative, and, if necessary, John Rogalski, assistant secretary of the State Society. Then take a rest; you deserve it.

The 'bullet ballot'—Is it worth the cost?

GEORGE A. ROWLAND, M.D.
Millville

The term "bullet ballot" has been a matter of discussion lately both in the Pennsylvania Medical Society House of Delegates and more recently at the AMA Convention in Anaheim. The idea is widely misunderstood, and I think it needs clarification.

In the simplest terms, any time a ballot is taken where the voter names his one choice of a candidate for a single office it is in effect a "bullet ballot." This goes without saying. It becomes a problem only when the election calls for a number of people to fill several equal positions as on a board or committee. Here the differentiation takes place between the "bullet ballot," a rifle bullet aimed at a single target, and a shotgun blast that is intended to name, for example, 3 out of 7 candidates. The shotgun type of election is used by PMS to name delegates and alternate delegates to the AMA, and the AMA has just determined to elect its trustees in this way rather than for "slots." "Slot" voting is the system by which the AMA has been electing trustees previously. Three totally undifferentiated positions are designated arbitrarily 1, 2, 3. Candidates are assigned to run for them and separate elections are held for each.

There are advantages each way. Voting for the group at large usually takes less time and trouble, and since the positions are interchangeable it seems foolish to single out each artificially identified "slot." In addition, it may avoid the loss of better candidates who might be set against each other while less desirable ones have little or no competition. On the other hand, a hotly contested "at large" vote ballot may require many repeated votes to get majorities for all vacancies. It also may encourage bullet balloting.

In such an instance bullet balloting is used by the supporters of one candidate. Take the example above. There are 3 positions to be filled from 7 candidates and 100 delegates voting. If all voters name 3 choices, the results might come out; candidate A-49, candidate B-48, candidate C-46, candidate D-44, candidate E-40, candidate F-37, candidate G-36, for a total of 300. Since no one received a majority of votes, a runoff is required. The bylaws might provide for this by dropping the one or two lowest (G or F and G) and balloting again for the others.

Consider what happens if ten of the supporters of candidate G decide to bullet ballot; that is to say they will vote only for their candidate, withholding any other names from their ballots. If 10 voters each withhold 2 votes, the total vote is now reduced from 300 to 280. Candidate G still gets 36 since they continue to name him, but candidate F will lose 5 votes which he would have received, dropping his total to 31. Candidate E loses 8 votes, dropping his total to 32. By this maneuver candidate G goes from seventh to fifth and will continue to be considered on the next ballot. His total remained the same while his opponents were diminished. If all 36 of G's supporters bullet ballot, his opponents will lose a total of 72 votes. The effect will be even more marked.

Those who favor "at large" votes suggest that the bullet ballot can be prohibited by counting only those ballots which contain the full number of names, in this case three. This would seem to have the disadvantage of requiring a voter to vote for candidates he finds personally repugnant. However, it is also quite possible for determined bullet balloters to overcome such a requirement. Additional nominations can be made from the floor, and the list can be stacked with less than serious candidates. Votes for such unknown or unpopular names still have the effect of withholding votes from serious candidates. Often it is not even required that votes be cast for individuals in nomination. This makes it easier to exercise a de facto bullet ballot.

If the practice of bullet balloting is used too much, it may be countered if the backers of all candidates vote for less than a full slate. This has the practical effect of turning the election back to "slot" voting.

There is a definite disadvantage to bullet balloting. Those who take advantage of it voluntarily give up their votes for other board members. In the last example above, let us say that all 36 bullet balloters for candidate G also would have favored candidate A. His vote would be reduced from 49 to 13 and he would be dropped from the list as having the lowest count on the first ballot. The bullet balloters may place one candidate on the board at the expense of losing all others who might in general favor their side.

In conclusion, the bullet ballot is a hazard whenever several equal offices are voted for simultaneously. In such a case it is almost impossible to legislate against it if bullet balloters are determined. If used too extensively, it loses its effect when all voters use the same mechanism. Its principal drawback is that those who make use of it disenfranchise themselves from the election of other candidates, sometimes with disastrous effects.

Dr. Rowland is a member of the State Society Board of Trustees, chairman of its Finance Committee, and a PMS delegate to the AMA. He is active also in the American Academy of Family Physicians.

Progress report

Accelerated medical graduates studied

WILLIAM K. GROSSMAN, M.D.
HAROLD GRAFF, M.D.
Philadelphia

Do accelerated medical graduates perform as well professionally as their peers?
Do accelerated medical graduates choose the same professional goals as their peers?
The Jefferson Medical College—Penn State University accelerated medical training program is evaluated.

Since the initiation of accelerated medical education in the past fifteen years, the number of such programs have grown at a rapid rate.[1] While some benefits such as decreased education time are obvious, evaluation of the programs can only begin as enough accelerated students complete their studies. The accelerated medical program begun at the Jefferson Medical College provides one of the longest and most comprehensive experiences with accelerated students, many of whom are now in internship, residency programs, and in practice. The program is also the best documented of the accelerated programs, and progress is charted in both the academic and psychological functions. At each phase of selection, of matriculation, of subsequent training, and of later life situation, evaluation procedures should be implemented to study the effects of acceleration on the later professional and social lives of the participants. The following questions are pertinent to this project: Are accelerated medical graduates performing as well professionally as their peers? Are they choosing the same professional goals? Are their personal lives different from those of their non-accelerated colleagues?

Literature Review

The Jefferson Accelerated Program began in 1963. It allowed students the opportunity to earn both the B.S. and the M.D. degrees in five calendar years after graduation from high school. Herbut and co-workers[2] and Conly[3,4] describe the program in detail. They found that the accelerated students perform, on the average, at least equally as well as their nonaccelerated colleagues in course work at Jefferson and in the tests of the National Boards of Medical Examiners. Menduke and co-workers[5] have concluded that the accelerated program attracted many people who would not have become physicians in the absence of this acceleration. Gottheil and co-workers[6,7] found that the accelerated students at Jefferson were not disadvantaged in their attitudes when compared with the nonaccelerated students with measures of performances, satisfaction, and subjective stress used in the study. Grossman and co-workers[8] found the accelerated students perceived themselves as indistinguishable from their nonaccelerated colleagues and had similar life experiences as students, with the exception that they married less frequently and studied more. Almost all felt accepted "as one of the group" by both their nonaccelerated colleagues and the faculty. Of those responding in that study, all concluded that the program be continued; 77 percent said they would choose to enter the five year program again rather than attend four years of college, and almost all replying at that time were satisfied with their career choice. Finally, Grossman and Conly[9] found that entering an accelerated program constituted a major life adjustment, high in pressure and rich in struggle and personal growth. In general the comments from the participants personal letters supported Herbut and co-workers[2] anticipated advantages and disadvantages of such an accelerated program.

Dr. Grossman is a fellow in medical education at Jefferson Medical College, Philadelphia. Dr. Graff is senior research scientist at the Hahnemann research division department of clinical sciences, Eastern Pennsylvania Psychiatric Institute, Philadelphia. At the time of the research, Dr. Grossman was chief resident in the adolescent treatment unit at the Institute of the Pennsylvania Hospital. He is the recipient of the hospital's Mathy Research prize for 1973. Dr. Graff is also research associate professor of psychiatry at Hahnemann Medical College and has recently been appointed consultant to the Special Action Office for Drug Abuse Prevention, Offices of the President, Washington, D.C.

Method

After the first five accelerated classes (1968 through 1972) graduated from Jefferson Medical College, a questionnaire and a Minnesota Multiphasic Personality Inventory (MMPI) were sent to the accelerated graduates and to a control group. (Copies of the questionnaire are available from the authors upon request.) The accelerated graduate was at least from the upper fifth of his high school class. He had a com-

bined score for the Scholastic Aptitude Test (SAT) of at least 1200 in the first year and greater than 1300 in subsequent years. He received his B.S. and M.D. degrees in five calendar years. The control graduates would have been qualified to become accelerated students had they applied. They fulfilled the traditional premedical training. Those graduates who did not so qualify, and/or whose precollege data was lacking, were eliminated from this study.

Rate of Return and Comments

The return rate varied little from year to year, and so the data was analyzed as a whole. In the accelerated group, thirty-two of 113 answered—for a rate of 28 percent. Fourteen of 129 in the control group responded—for a return rate of 11 percent. The authors readily admit that the percentages of the responses were small and that comparison in the usual statistical sense is difficult, but believe that the findings are preliminary evidence that the graduates of the first five accelerated classes at Jefferson have had a favorable experience after graduation when compared with the control group.

Personal Life Data: The average age of the accelerated respondent was twenty-six years. Almost all were male. Seventeen of the thirty-two responding were first-born and thirteen were second-born. More than half responding (17) were Jewish, seven protestant, two Catholic, one atheist, and one no religious preference, with three not responding.

The average control graduate was twenty-eight years old; almost all were male. Eleven of the fourteen responding were first-born and two were second-born. There was no predominating religious preference.

Career History: In general, both accelerated and control graduates felt good about career choice, internship, and residency. Only one individual in either group had any extensive experience in private practice. Of the accelerated graduates, half had straight medical internships, another ten selected rotating internships, and the others scattered their choices. Of those in residency programs, ten chose a medical residency and the remaining choices were scattered among other residency programs. Five of the thirty-two were awarded fellowships. Ten had their careers interrupted for military training.

On the other hand, half of the control graduates chose rotating internships with the rest of the choices scattered. There was no trend in residency choice. One of those responding was awarded a fellowship. Three had their careers interrupted for military training.

Two-thirds of the accelerated graduates spent more than five hours a week in medical reading. Twelve of the fourteen controls spent more than five hours a week in medical reading.

When asked for consideration of to which discipline they expected to devote 33 percent or more of their time, twenty of thirty-two graduates responding said private practice, another nine said academics, four research, three community service, and one stated administration. Corresponding figures for the control graduates were eleven of fourteen controls responding said private practice, one research, four in community service, and two in administration.

Personal History: Twenty-four of thirty-two accelerated graduates were married, one was separated, and seven of those married had children. Comparable figures for the controls were: eleven of the fourteen in the control group were married, four of these had children. In both groups almost all owned cars with no difference in the type of automobile preferred.

Uniformly, the accelerated graduate felt great feelings of self-worth and a high to great feeling of maturity; the controls, on the other hand, had good feelings of self-worth, with a high to great feeling of maturity. Six of thirty-two accelerated graduates reported emotional difficulties, with four having depression and two situational adjustment reactions. Twenty of thirty-two reported a weight gain or loss of 5 pounds since graduation. Seven of the thirty-two reported experiencing physical illnesses: two impotence associated with depression, two mononucleosis, one hepatitis, one ankylosing spondylitis, one allergic reaction. Drugs such as lysergic acid, amphetamines, barbiturates, and morphine were almost never used. There was occasional to frequent use of both alcohol and marijuana.

Two of thirty-two interrupted their training for psychiatric reasons, but only three reported to have been in psychotherapy at any time. Comparable figures for the control group are: four of fourteen reporting emotional difficulties, three depressions, and one anxiety reaction. None reported a weight gain or loss of greater than 5 pounds. None reported any other illnesses. Drugs such as lysergic acid, amphetamines, barbiturates, and morphine were almost never used. There was occasional to frequent use of marijuana and alcohol. None interrupted their training for psychiatric reasons. Four of fourteen are presently in psychotherapy.

Minnesota Multiphasic Personality Inventory (MMPI) Results: Several categories were consistently high for both the accelerated and the control group. The only one of the main diagnostic scores which was high for both was the MF (male-female) Scale. This high score is usually found among people with higher educational and esthetic interests. Both groups scored high in research categories designating ego strength, dominance, and social status. There were no high scores for the accelerated group that were not high for the control group, but the controls were high in the MA (hypomania) and low back pain (a diagnostic score for research purposes). None of the accelerated group showed a high pathologic score, while five of the control group showed self-depreciation, social introversion, physical and emotional difficulties, and even one who showed evidence of psychopathology.

Subjects Evaluation of the Accelerated Program: When the accelerated group was asked whether they would participate in the accelerated program again, twenty-eight of the thirty-two replied affirmatively, and the same number would recommend the program to others. Of the control group, only seven of fourteen would recommend the program to others.

Conclusion

As accelerated medical programs continue to proliferate, we believe their graduates should be viewed periodically with regard to their career development and their personal lives. This paper attempted to evaluate the graduates of the first five accelerated classes

to graduate from the Jefferson Medical College of Thomas Jefferson University and the Pennsylvania State University's accelerated program. At this time, it appears that the accelerated graduates are having a favorable experience when compared with the nonaccelerated graduates. While they lead remarkably similar lives, there is preliminary evidence that the accelerated graduate is more likely (1) to be Jewish; (2) to take residency training in internal medicine; (3) to be more interested in academics and to receive more fellowships; (4) to be more prone to weight gain and loss and illness; (5) to be less frequently engaged in psychotherapy but to have more career interruptions due to emotional difficulty; (6) to be less likely to show pathologic scores on the MMPI; and finally, (7) to be more likely to recommend his training program to others.

While dissimilarities could be accounted for by random selection alone, it is our opinion that these are trends which subsequent follow-up studies should follow closely. These authors agree with both Herbut and coworkers[2] and Conly[3,4] that the first ten years of the Jefferson-Penn State Accelerated Program have been successful and that the experiences of the program participants have been favorable. □

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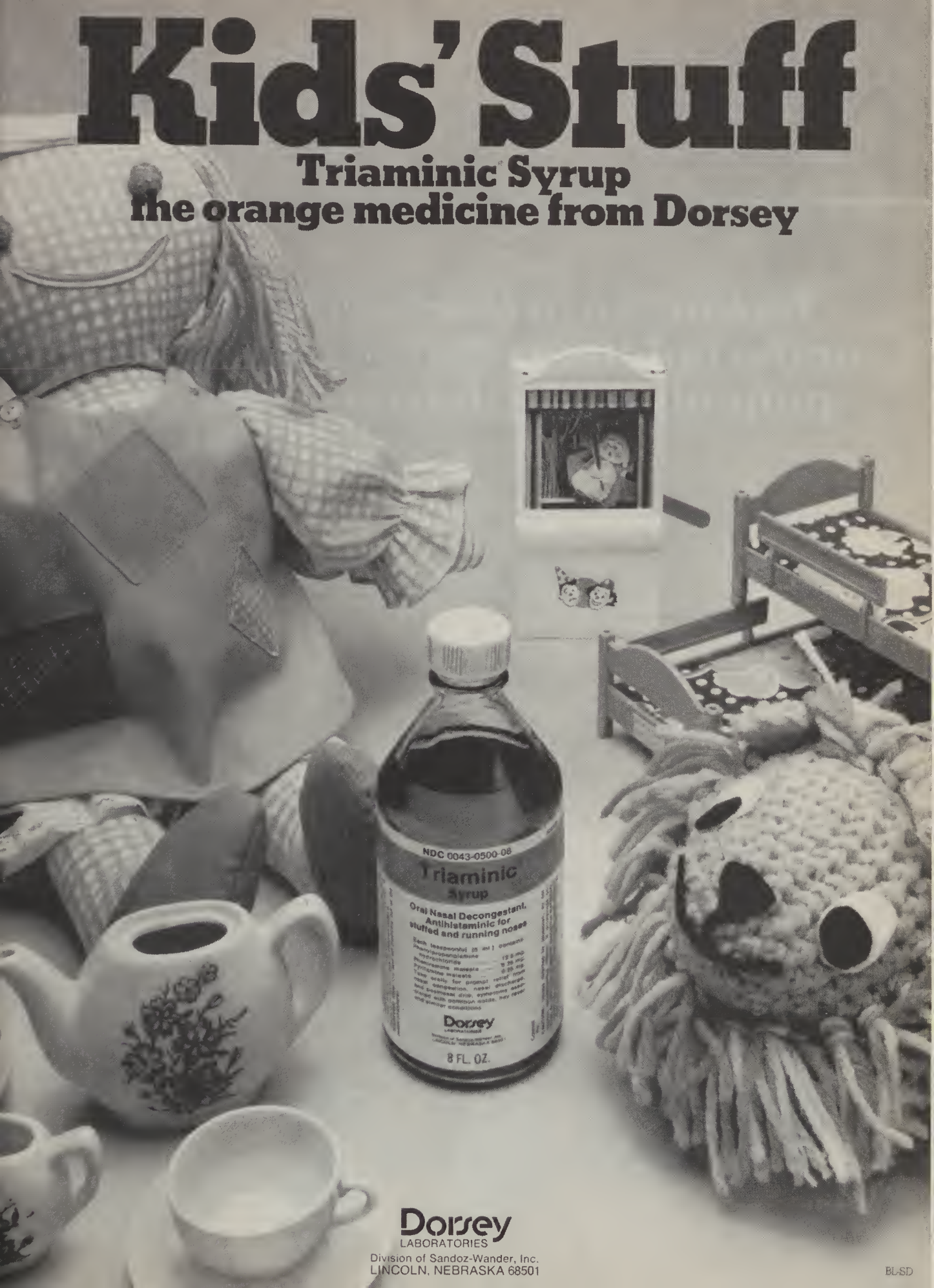

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Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

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Pennsylvania civil commitment procedures: A practical guide

ALAN MEISEL, J.D.
Pittsburgh

The Mental Health and Mental Retardation Act of 1966 (MH/MR Act)[1] provides for four different procedures for the civil commitment of patients to receive psychiatric care: (1) voluntary admission (§402); (2) voluntary commitment (§403); (3) emergency commitment (§405); and (4) civil court commitment (§406). A fifth procedure authorized by the MH/MR Act, commitment on the certificate of physicians, has been declared unconstitutional[2] and consequently may no longer be used. In addition to their applicability to the commitment of individuals to receive psychiatric care, these same procedures are mandated for use in the commitment of individuals to receive treatment for alcoholism and drug addiction.[3]

In addition to the civil commitment procedures, the MH/MR Act also authorizes several procedures for the commitment of individuals involved in the criminal process.[4] Rarely, if ever, is a person needing psychiatric care who is in jail awaiting trial or sentencing or who is in prison serving a sentence committed to a private facility or one under contract to provide services to a county mental health and mental retardation system. Rather, such individuals are usually committed to Farview State Hospital or to another hospital in the state hospital system. Consequently, the criminal commitment procedures will not be discussed in this article.

The intention instead is to provide a roadmap through the civil commitment procedure maze for hospital personnel, private practitioners, and possibly attorneys. No implication of approval is intended. In fact, it is not unlikely that at least one of the procedures—emergency commitment—is unconstitutional. Further, all of the procedures may at times be administered in an illegal fashion.

Voluntary Admission—§402

This section of the statute is intended to provide a means by which an individual may voluntarily obtain and discontinue psychiatric care in much the same way that a patient may receive medical or surgical care.

Standards for Use of §402

(1) Applicant must be eighteen years of age or older. (§402(a) (1)).

(2) Applicant must be found to be "in need of care or observation." (§402(b)).

(3) Special procedures for juveniles (See Special Rules Applicable to Children below).

Examination and Commitment Procedures

(1) Application[5] is completed.* If the patient refuses to sign, but indicates verbally that he wishes to be hospitalized, this fact should be noted in the medical record and the patient may then be voluntarily admitted.

(2) Applicant undergoes a psychiatric examination (§402(b)).

(3) The hospital may, but is not required to, admit the patient if he is found to be in need of care or observation (§402(b))

**The statute does not state that the application for a voluntary* admission *must be in writing, nor that it may be oral. However, §403 specifically states that the application for a voluntary* commitment *must be in writing. Thus, the implication may be drawn from the presence of this requirement in one section of the statute (§403) and its absence in another similar section (§402) that there is no requirement of a written application in the latter procedure.*

Mr. Meisel is a research associate in psychiatry and director of the law and psychiatry section of the Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine. *The author wishes to acknowledge the assistance of Anne Maxwell, director of information referral and emergency services, Allegheny County Office of Mental Health and Mental Retardation.*

Termination of Hospitalization

(1) Patient is free to leave at any time. (§402(c)).

(2) Leave of absence (See Termination under §406 below).

Review of the Hospitalization

(1) A committee comprised of members of the professional staff of the hospital, appointed by the director, is required to review at least once annually the status of each voluntarily admitted patient (§402(d)).

(2) The committee is required to make written recommendations to the director as to whether continued care is necessary. These recommendations must be kept on file in the hospital (§402(d)).

Voluntary Commitment—§403

The voluntary commitment resembles the voluntary admission in that the patient consents to hospitalization. However, egress from the mental health system is subject to restriction, which is not so in the case of voluntary admissions. The voluntarily committed patient may be detained for ten days beyond the time he notifies the hospital of his wish to be discharged. However, during this ten-day period, proceedings may be instituted to retain the patient in the hospital on an involuntary basis (§406).

Standards for Use of §403

(1) Applicant must be eighteen years of age or older (§403(a) (1)).

(2) Applicant must be found to be "in need of care or observation." (§403(b)).

(3) Special procedures for juveniles (See Special Rules Applicable to Children below).

Examination and Commitment Procedures

(1) Application[6] must be written. (§403(b)).

(2) Application is to be signed by the applicant in the presence of one witness (§403(b)). If the patient ref-

uses to sign, but indicates verbally that he wishes to be hospitalized, this fact should be noted in the medical record and the patient may then be voluntarily committed.

(3) Applicant undergoes a psychiatric examination. (§403(b)).

Duration and Extension of Hospitalization

(1) Not to exceed thirty days (§403(b)).

(2) An unlimited number of extensions may be made, as long as care or observation remains necessary, for periods of not more than thirty days each. Extensions are made by having the patient complete a new application for voluntary commitment (§403 (b)).

Termination of Hospitalization

(1) Patient may be detained a maximum of ten days beyond the time he notifies the hospital of his intention or desire to be discharged (§403(c)).

(2) "[T]here is no justification for holding a patient beyond the ten-day limit"[7] without initiating, prior to the expiration of the ten-day period, either a §405 emergency commitment or a §406 court commitment.

(3) A §405 emergency commitment may be initiated only if the patient is dangerous to himself or others (See Emergency Commitment below).

(4) If the patient is not dangerous but still requires hospitalization, he may be committed pursuant to §406 (See Civil Court Commitment below). However, because the voluntarily committed patient has likely chosen to be hospitalized knowing that he will be able to terminate the hospitalization on ten days' notice, the filing of a petition to have the patient involuntarily committed tends to undermine the voluntariness of the procedure. Thus in order to protect the integrity of voluntary hospitalization and the safeguards which it affords the patient as well as the usefulness which it has to the hospital, the courts sometimes take a dim view of the filing by a hospital of a §406 petition to have involuntarily committed a person who is already voluntarily hospitalized. Thus where the treatment personnel feel that further hospitalization is required, a third party—a family member when available, or a staff member of the office of the County Administrator of MH/MR—should act as the petitioner. While legal counsel to the Department of Public Welfare has advised that a hospital staff member may petition for court commitment,[8] it is a matter of local judicial practice as to whether or not a hospital staff member will be acceptable as a petitioner.

(5) Leave of absence (See Termination under §406 below).

Review of Commitments

(1) A committee comprised of members of the professional staff of the hospital, appointed by the director, is required to review at least once annually the status of each voluntarily committed patient (§403(d)).

(2) The committee is required to make written recommendations to the director as to whether continued care and commitment are necessary. These recommendations must be kept on file in the hospital (§403(d)).

Emergency Commitment—§405

An emergency commitment, unlike the voluntary admission and voluntary commitment, is a form of involuntary hospitalization used to commit individuals who are believed to be mentally ill and dangerous. Section 405 is not a preventive detention statute. No person should be hospitalized under this provision unless there is reasonable cause to believe that his presence in the community constitutes a clear and present danger to his own or to another person's life. Because dangerousness is extremely difficult to predict accurately,[9] this procedure should be used extremely sparingly and cautiously.

Standards for Use of §405

(1) Person must be "so mentally disabled as to be dangerous to himself or others and in need of immediate care." (§405(a)).

(2) In assessing the person's dangerousness, the physician must find that "The acts or threats which give cause to believe the person [is] mentally disabled and in need of immediate care are overt, [and] demonstrate a clear and present danger to self or others. . . ." (§405 (a) (2)).

(3) "Mental disability" is defined in the MH/MR Act as "any mental illness, mental impairment, mental retardation, or mental deficiency, which so lessens the capacity of a person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care. . . . This term shall not include senility, unless mental illness or mental retardation is superimposed." (§102).

Examination and Commitment Procedures

(1) The person sought to be committed must be examined by a physician. (§405(b)).

(2) If the person refuses to go voluntarily to be examined, he must be taken into custody in order to be examined. The office of the County Administrator of MH/MR will give permission to take the person into custody if it is demonstrated that the person is dangerous and in need of immediate care.* Ordinarily, the authorization will be given for the police or for an ambulance to take the person into custody, though if he is not protesting too vigorously, permission may be given to a relative, guardian, friend, or individual in loco parentis ** (§405(a) (1)).

(3) Psychiatric examination is performed (§405(a) (1)).

(4) If the examining physician determines that the person is in need of immediate emergency care and is "dan-

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**Failure to obtain approval from the County Administrator of MH/MR may expose treatment personnel to liability for false imprisonment of the individual. While §603 of the MH/MR Act grants immunity from liability for acts performed "in good faith and not falsely, corruptly, maliciously, or without reasonable cause," it does not absolutely immunize treatment personnel from legal liability.*

***"A person standing in loco parentis to a child is one who has put himself in the situation of a lawful parent by assuming the obligations incident to the parental relation, without going through the formalities necessary to a legal adoption. . . ." Commonwealth v. Benjamin, 76 D & C 47, 48 (1950); see also Commonwealth ex rel. Morgan v. Smith, 429 Pa. 561, 241 A.2d 531, 533 (1968). A school teacher does not stand in loco parentis to a student for the purpose of obtaining medical treatment. Guerrieri v. Tyson, 147 Pa. Super. 239, 24 A.2d 468 (1942).*

gerous," he completes the required certificate.[10]

(5) If the examining physician determines that the person does not meet the criteria for commitment under §405, the patient is to be released from custody at the place where he was taken into custody. However, if he was taken into custody by a police officer and has committed a crime, the patient should be released to the police officer who is responsible for arranging for criminal disposition (§405(d)).

(6) Unless the original application to the County Administrator of MH/MR for emergency detention was made by a relative or guardian, notice of the person's commitment must be given to a relative or guardian (§405(c)).

Duration, Termination and Extension

(1) Maximum hospitalization of ten days. (§405(f)).

(2) Patient may voluntarily remain beyond ten days. In this case, patient should complete the necessary forms for a voluntary admission or a voluntary commitment. (§405(f)).

(3) In order for the patient to be hospitalized against his will beyond the expiration of the ten-day period, two conditions must be satisfied: (a) the patient must continue to be dangerous to himself or others, and (b) a petition for court commitment pursuant to §406 must actually have been filed prior to the expiration of the ten-day period. Only when both of these conditions are satisfied may the patient legally be held beyond the expiration of the §405 commitment.[11]

Civil Court Commitment—§406

Like the emergency commitment procedure of §405, this section authorizes a form of involuntary hospitalization. However, the critical distinction between the civil court commitment (§406) and the emergency commitment (§405) is that the decision as to whether involuntary hospitalization will be ordered is made by a judge, rather than by the joint efforts of a physician and the County Administrator of MH/MR. Furthermore, the court commitment may be for an indefinite period of time while the emergency commitment is strictly limited to ten days.

Standards for Use of §406

(1) Person is "mentally disabled" and "in need of care or treatment by reason of such mental disability." (§406(a)).

(2) "Mental disability" has the same meaning as that indicated in the Emergency Commitment procedure of §405.

Examination and Commitment Procedures

(1) Person sought to be hospitalized must receive a psychiatric examination. (§406(b)). If the person voluntarily agrees to examination or is presently hospitalized under §402, §403, or §405 and has already been examined, the next step in the commitment procedure is item (5) below.

(2) If the person will not voluntarily undergo the psychiatric examination, a petition for examination must be filed with the Orphans' Division of the Court of Common Pleas. (§406(a)). The petition may be filed by a relative, friend, individual in loco parentis, a governmental or nonprofit health or welfare agency, or any "responsible person."* (§406(a) (1)). The petitioner may obtain aid in completing and filing the petition from the office of the County Administrator of MH/MR. The petition should state the facts on which the petitioner bases his belief that the person sought to be hospitalized is mentally disabled (§406(a) (2)).

(3) The court, at a motions calendar, sets a date for a preliminary hearing and issues a bench warrant directing the sheriff to insure the respondent's (i.e., the prospective patient's) presence at the preliminary hearing (§406(a) (2)).

(4) Preliminary hearing: The court hears the petitioner's testimony as to why the respondent ought to be ordered to undergo a psychiatric examination. At the conclusion of the hearing, the court either (a) releases the respondent, (b) orders an immediate examination by two court-appointed physicians, (§406(a) (4) (i)), or (c) commits the respondent for a period not to exceed ten days* for the purpose of examination (§406(a) (4) (ii)).

(5) Whether the person sought to be hospitalized has voluntarily or involuntarily undergone psychiatric examination, the court must hold a hearing to consider the results of the examination (§406(b)). Separate written and notarized reports are submitted by the two examining physicians stating the condition of the patient, their diagnosis, and recommendation. While either the petitioner or the respondent may compel the presence of both physicians at the hearing, it is customary for only one physician to appear and testify. Whether or not the respondent attends the hearing is usually determined jointly by the respondent's attorney** and the examining psychiatrist(s), though the respondent's attorney is the final arbiter of this issue should there be a divided opinion.

(6) If the court determines that the individual is "mentally disabled and in need of care or treatment by reason of such mental disability," it issues an order committing the respondent to inpatient care, partial hospitalization, or outpatient care (§406(b)). Otherwise,

A "responsible person" is one who is legally responsible for the care of the person in question. Commonwealth v. Barnes, 280 Pa. 351, 124 A. 636 (1924); Commonwealth v. Kuhns, 77 Pitts. L.J. 773, 17 West. 4 (1927).

Though the statute clearly states that the period of hospitalization for examination is not to exceed ten days (§406(a) (4) (ii)), patients are often detained for a longer period because of the court's inability to schedule a hearing within ten days or because of the inability of the sheriff to arrange for transportation of the patient to the hearing within that period. Since the statute states that the purpose of the ten-day hospitalization is for "examination," the question sometimes arises as to whether the patient may be "treated" during this period. At present, there is no judicial or legislative resolution to this problem.

**Free legal counsel must be provided to indigent respondents. In some counties, the public defender serves as counsel for the respondent. See Purdon's Pennsylvania Statutes Annotated, title 16, §9960.6(c). In others, private counsel may be obtained to represent the respondent by the office of the County Administrator of MH/MR.*

the respondent is released from further hospitalization.

Termination

(1) If at any time the patient is deemed not to be in need of care and treatment, he must be discharged or granted a leave of absence (§418).

(2) Leave of Absence: The hospital may allow a patient to be placed on a leave of absence for a period not exceeding one year (§419(a)). Before granting an extended leave of absence, the attending psychiatrist should submit to the court who committed the patient a letter in the form of a progress report stating the intention to grant a leave of absence and describing the follow-up procedures, if any, to be employed. This procedure will afford the interested parties an opportunity to protest the leave of absence, in which case a hearing will be held to resolve the dispute.

(3) A leave of absence may be terminated by the hospital. If necessary, it may authorize the apprehension and return of the patient by a law enforcement officer (§419(b)).

(4) Extensions of a leave of absence for a period not to exceed one year may be granted (§419(a)). However, whenever a leave of absence is granted and extended to a period of three years and not terminated by the hospital, it automatically expires at the end of three years, and the patient is discharged (§419(c)).

Special Rules Applicable to Children

(1) An applicant for hospitalization who is under age eighteen years may not admit himself. (§§402(a) (1), 403(a) (1)).

(2) An application for admission on behalf of a person under age eighteen may be made by a parent, guardian, or an individual in loco parentis. (§§402(a) (2), 403(a) (2)).

(3) Children who are wards of the court should be committed pursuant to §406 rather than §402 or §403.

(4) A child who is "life threatening" should be committed pursuant to §405 rather than §402 or §403.

(5) Child seeks admission; parental consent is absent: The following is a list of persons, although under age eighteen, who may give a legal consent to obtain medical treatment, and thus presumably may be hospitalized in the absence of parental consent, or even over parental objection: (a) minors who have graduated from high school; (b) minors who are or have been married; (c) minors who are or have been pregnant.[12]

Furthermore, consent of neither the child nor a legally responsible person is required if "an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life or health."[13] Finally, an "emancipated child"* may also give valid legal consent to medical treatment.[14,15,16] Should the child not fit into any of the categories of children who may give valid legal consent, a petition for commitment under §406 should be filed in juvenile court.

(6) Parent seeks admission; child objects: If the child is under age thirteen, he may be hospitalized irrespective of his own objections. If the child is between ages thirteen and eighteen, the following procedure must be followed:[17,18] (a) Within twenty-four hours of the child's admission, he must receive notification of his legal rights in a form issued by the Department of Public Welfare.[17(p.1841)]The statement should be read and signed by the patient, and its contents must also be explained orally to him. (b) If the child objects, either orally or in writing, to being hospitalized, he may be detained for a maximum of two business days if the hospital feels that continued hospitalization is indicated. The child's mere refusal to sign the statement of his rights should not necessarily be interpreted as an objection to hospitalization but should be noted in the medical record. (c) If the child objects to being hospitalized, the hospital must notify immediately all parties in interest (parents, guardian, child welfare worker, etc.) as well as the office of the County Administrator of MH/MR. (d) Unless one of these parties then files a petition to have the child judicially committed, the child must be released within two days. The party seeking to have the child committed should contact the office of the County Administrator of MH/MR for aid in the completion of the necessary forms and to arrange for a "shelter hearing" in juvenile court. (e) Shelter Hearing is the formal designation given to the procedure in which the petitioner and the juvenile court intake worker present the commitment petition to the judge, who issues an order setting a time for a commitment hearing and permitting the hospital to continue to hold the child for longer than two days when necessary. (f) Commitment Hearing: The purpose of the hearing is to determine whether, on the basis of the medical examination, the child ought to be released or remain hospitalized. The standards for this hearing are the same as for a judicial commitment pursuant to §406 (See Civil Court Commitment above). □

The determination of whether or not a child is emancipated is often quite complicated and is beyond the scope of this article.

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Impact of multiphasic health testing on the future of traditional medical practice

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It is 1930 and Sam Brown, a typical patient, consults his physician because he has lost some weight and is now having difficulty with his bowel movements. Sam has not visited his physician for many years and indeed would not be making this visit if he had not been coerced by his wife. Sam and his neighbors don't go to the doctor unless they are sick. There are a few executives who do go to the doctor for a regular examination, but generally regular examinations are the privilege of the few who can afford the time and the money to go to the doctor when they don't have any symptoms. The few who do get regular examinations do not have laboratory studies done unless a specific abnormality is found on history or physical. Sam's doctor feels that periodic physicals are good; but if he were to examine each patient in his busy practice every year, he would have no time to treat his patients who are ill. On this visit Sam's physician pays careful attention to the gastrointestinal examination because this is the area of the presenting complaint. He misses the fact that Sam has developed diabetes because Sam does not mention these symptoms, and no blood test is done. Physical examination of Sam's rectum reveals a large constricting mass, and Sam goes on to die two years later of cancer of the rectum.

It is 1980 (or 1973 in many large cities[1-3]) and Sam's son, Sam Jr., is about to visit his physician for his regular health examination. Sam Jr. knows the value of preventive medicine because he has seen advertising and editorials which explain its value. Before seeing the physician, Sam sits at a computer console and presses buttons to answer questions of his medical history as they are presented on a screen. If Sam gives a positive answer to a certain question, a different branch of questioning is taken to more fully elucidate his sympton comlex. Following the medical history, Sam Jr. is given an extensive battery of tests which include a hemogram, chest x-ray, 12-test biochemistry profile, audiometry, electrocardiography, spirometry, and facial thermography. Well-trained paramedical physicians' assistants take his blood pressure and examine him physically. Finally, Sam Jr. presents himself to his physician who has Sam's computer tabulated history, physical, and test results. The physician repeats or further explores any aspects of the report which he thinks deserve further attention. He orders any further profiles of tests which are indicated. Sam's physician has more time to spend talking with him and evaluating him because he has been freed from the routine work by paramedical personnel. Periodic health testing is available to everyone because insurance companies and a government subsidy pay for all but a fraction of the cost. In Sam Jr.'s case, the cost is included in the annual fee which he pays to his health maintenance organization (HMO).[4,5] The HMO encourages periodic health examinations because it views the maintenance of health as its primary obligation. Sam Jr. has come to view good health as the right of everyone and not the privilege of a few.

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Thus, in one generation, the very concept of health care has undergone a radical change. The chief factors responsible for this metamorphosis are technological advances and the advent of multiphasic health testing.

Multiphasic health testing should be distinguished from multiphasic health screening. Screening basically is testing done upon an unselected population; whereas health testing is done upon a preselected target population.[6] Sometimes this is a rather fine distinction because the health testing profile is modified on the basis of age, sex, medical history, and previous screening results as well as other parameters. Multiphasic health screening is not a completely modern concept. During the American Civil War, medical screening of recruits by means of medical examinations was done on a large scale. The description of "Soldier's Heart" or circulatory asthenia grew out of this large scale screening. During World War II a similar screening process uncovered mental disturbances in a large number of men.

Modern Automated Multiphasic Health Testing (AMHT) really began in the 1960s. During this decade, experimental research teams of scientists in such disciplines as electronics, computer technology, biochemistry, and clinical pathology with assistance from internal medicine and aerospace research, first put together automatic clinical laboratory devices.[7,8] Soon thereafter they rapidly added data processing systems capable of storage and retrieval of all types of information that had customarily been hand-operated and recorded. It was possible to automate and automatically record

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history taking and a multitude of clinical tests.[9] Beginning in the 1970s centers have opened which seek to demonstrate the cost effectiveness of such large scale automation of medical care. The large initial start-up costs of the automated centers have confined sponsorship to government agencies, foundations, and corporations—both profit and non-profit.[10,11] However, it has been shown that as the number of people tested rises, the cost per patient falls.[12] This shows that health testing is now feasible for large segments of the population. The health testing examination described for Sam Jr. in the beginning of this article would cost $55.00 at the Medicheck center in Sydney, Australia. Because of government subsidies, the cost to the patient is $8.10.[13]

The advances of automated multiphasic health testing as with most of the technologic advances of our society, have not been without criticism. Most of this centers around the absence of long-term proof that early detection of illness can materially influence the natural course of the disease. Also a claim is made of low yields and high cost per detected illness. Many illnesses can be benefited by early detection, however.[14] Cost per detected illness is only a partial indication of the true value of AMHT. Cullen in 1970 analyzed 44,663 examinations carried out over a twelve month period.[15] The single most costly procedure was detection of breast cancer ($408 per positive mammography finding) and the least expensive was hearing impairment ($1.55 per positive test result). Yet, unstated here is the value of the negative test results in reassuring the worried well. Also unmentioned is the reduced cost of treating early detected illness as opposed to late detected disease with its attendant prolonged hospitalizations. Notwithstanding criticism, automated multiphasic health testing is achieving greater acceptance and will be more widely used in the future.[15-17]

The Physician as Healer

Throughout history, it has been the physician's role to heal the sick. People did not visit the healer until they were obviously unwell, or at least thought they were unwell. This was a major problem because the lay public was placed in the role of deciding when medical care was needed. A not unexpected result was (and still is) that many of the patients appearing in a doctor's office do not have anything wrong with them other than an apprehension or an ungrounded fear that something might be wrong with them. A more tragic result of this traditional medical practice of letting the lay public decide when a physician should be consulted is that many people who would be treated by a physician do not appear early enough in the course of their disease. The impact of AMHT upon this traditional medical practice is to remove the responsibility of determining who should be treated by a physician from the lay public and placing it in the hands of physician-directed paramedical personnel and automated screening devices. The physician will retain his role of healer of the unwell. But he will assume, through the use of AMHT, a new role of preventor or early detector of illness.

Fee for Service

This is a long-standing tradition of medicine. Simply stated, this is the doctrine that doctors have a right to be paid for performing a service which traditionally has been the healing, or least the attempted healing, of a person who has become ill. The impact of AMHT upon this dictum is that now physicians have the capability of extending their service to include the early detection and prevention of illness. Because the prevention of illness is a life-long task versus the much shorter term of treatment of illness, and because of the large

investment and volume required to maintain AMHT, physicians will be obligated to consolidate their services.[18] This may be in large group practices, health maintenance organizations, or government clinics.[19] If the physician is to be paid for the maintenance of a patient's health rather than the treatment of illness, payment must necessarily be on an installment basis at periodic intervals. This type of departure from the traditional mode of payment of medical treatment is amenable to payment by a third party whether it be an insurance carrier or a government agency.

Role of the Patient

Traditionally, the patient has assumed the role of a purchaser of health care, which he purchased when he decided that he was in need of health care. The maintenance of his individual health has been his personal responsibility. He had no duty to obtain health care and no right to receive it. He only contracted for a service when the service was needed. Now, with AMHT and the ability to prevent disease or at least monitor for early detection, the relationship is changed. Widespread maintenance of health is available and indeed necessary if the volume needed to make AMHT feasible is to be achieved. High initial costs and widespread availability will lead to government or foundation support and, to some degree, control. Payment by government and large third parties implies the obligation to provide equal health care to all. At this point health maintenance becomes the right of the patient and not a privilege to be purchased.

The Physician in Patient Care

Traditionally, the physician as healer has provided almost all services necessary to heal a patient. He has been loath to delegate any of this responsibility. The nurse, pharmacist, and laboratory technician have been allowed to help him in his role, but only under the strictest supervision and in very clear, limited areas. The history, physical examination, ordering of tests, and assimilation of data have been the exclusive domain of the physician. AMHT infuses computer, computer specialists, and physicians' assistants into this domain. Computerization and AMHT, along with highly trained paramedical personnel, can take over a part of this duty from the doctor. Since health care is the responsibility of the physician, supervision of care will remain exclusively in his hands.[20] However, AMHT will allow him to extend his hands and his training to people who would otherwise not have the benefit of these. Worldwide, except for the urban areas of the industrialized counties, there is a shortage of physicians. With the concept of health maintenance as a right, there will be a massive influx of patients upon the already overworked physicians of the world. AMHT will allow the physician not only to cope with the increased load of patients but to devote more time to each patient because AMHT will free him from much of the routine work which consumes the majority of his time. In a sense, physicians may return to an earlier concept of the role of a physician—that of a healer who is a man relating to his fellow man.

Conclusion

AMHT is a two edged sword. While it may depersonalize medical care, divert valuable resources, and destroy the free enterprise individuality of medicine, if used properly it can restore the personal contact so important to medicine and also be the harbinger of health through preventive medicine for the people of the world. □

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We can eliminate tetanus in the United States

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Tetanus continues to occur as a complication of lacerations, compound fractures, burns, abrasions, hypodermic injections, operations on the gastrointestinal tract, and birth (infection of the umbilical stump in the newborn). In addition it occurs in individuals in whom no responsible wound can be demonstrated.

Recently the writer has been consulted in regard to tetanus in a 20-month-old male, in a 43-year-old female, and in a 27-year-old female. These cases of tetanus were the result of lacerations of the back and arm, of a dog-bite of the leg, and of a bush splinter in the foot respectively.

Tetanus also may be associated with professional liability problems. For example, several years ago there was a $2,074,250 suit which was filed in view of a case of tetanus. The plaintiff, a 31-year-old female, developed tetanus as the result of a leg laceration.

In spite of such problems, however, *observation of the following by physicians and nonphysician citizens* could result in the complete elimination of tetanus in the United States:

(1) Administration of tetanus toxoid when indicated.
(2) Immediate, meticulous, surgical care of all wounds of violence.
(3) Proper employment of tetanus immune globulin (human).
(4) Proper use of emergency medical identification devices.

Tetanus toxoid should be administered when there is an indication for its injection. In the United States at the present time, emphasis is being placed upon not how *frequently* a tetanus toxoid booster should be given but on how *infrequently* a tetanus toxoid booster should be given. Tetanus toxoid has become one of the most effective antigens which have been developed. Too frequent and unnecessary doses of tetanus toxoid could result in unnecessary reactions to tetanus toxoid so that individuals would not ask their physicians for indicated doses.

For the prophylaxis of tetanus, the importance of adequate initial surgical care of wounds has been and is still emphasized. Thorough and gentle cleansing and debridement of wounds — at times leaving them open — remain two of the most important features. Necrotic tissue and foreign bodies can be massively contaminated with *Clostridium tetani* and can serve as a nidus in which the lethal toxin can be produced. Therefore, removal of such tissue and foreign bodies is important. If the wound is extensive or old, conversion of an anaerobic environment to an aerobic environment by leaving the wound wide open and with drainage is indicated.

Tetanus immune globulin (human), known also as TIG (H) or human tetanus antitoxin, has been referred to by at least twenty-five other scientific or trade names in the literature and in advertisements. Since significant reactions to TIG (H) do not occur for all practical purposes, there has been a tendency to administer this antitoxin when it is not indicated and to forget that it must be obtained from human volunteers.

Simultaneous active-passive immunization with toxoid and TIG (H) is possible and most effective; and such immunization should be practiced when necessary. Unusual indications for simultaneous administration of toxoid and TIG (H) to the wounded are: (1) Agammaglobulinemia; (2) Recent exposure to radioactive substances; (3) Recent exposure to immunosuppressive agents (Chloramphenicol is to be included in this group, for commonly employed therapeutic amounts of chloramphenicol to treat infections in man suppress the anamnestic response to tetanus toxoid); and (4) Carcinoma of the breast.

It would indeed be a tragedy for a renal or cardiac transplant patient, who has had his immune mechanisms altered to prevent transplant rejection and who suffered a minor wound, to develop tetanus and to die since an administered toxoid booster did not produce the usual active antitoxin response and since the patient was not given TIG (H) in addition to toxoid!

All too frequently, the victim of trauma does not have on his person a properly documented emergency medical identification device with the dates of tetanus toxoid injections. An incorrect belief that an injured person has had adequate prior tetanus toxoid immunization might result in giving only tetanus toxoid when the administration of both it and TIG (H) were indicated and might result in the patient developing tetanus.

During the past few years, the *Weekly Reports* from the United States Public Health Service Center for Disease Control in Atlanta, Georgia, emphasize that, with proper prophylaxis, tetanus is being diagnosed less frequently in the United States. According to the December 1, 1973 *Weekly Report*, for the first forty-eight weeks of the years during the period 1968-1972, a median of 126 cases of tetanus for the entire United States was reported. For the first forty-eight weeks of 1972, 110 cases were reported; and only eighty-three cases were reported for the first forty-eight weeks of 1973.

More than a decade ago, President Kennedy predicted that man would be on the moon within ten years; his prediction was confirmed. *Hopefully, with the means available in the United States and in view of the figures quoted above, by 1980 at the latest, tetanus will no longer occur in the United States and will have become a disease of only historical significance.*

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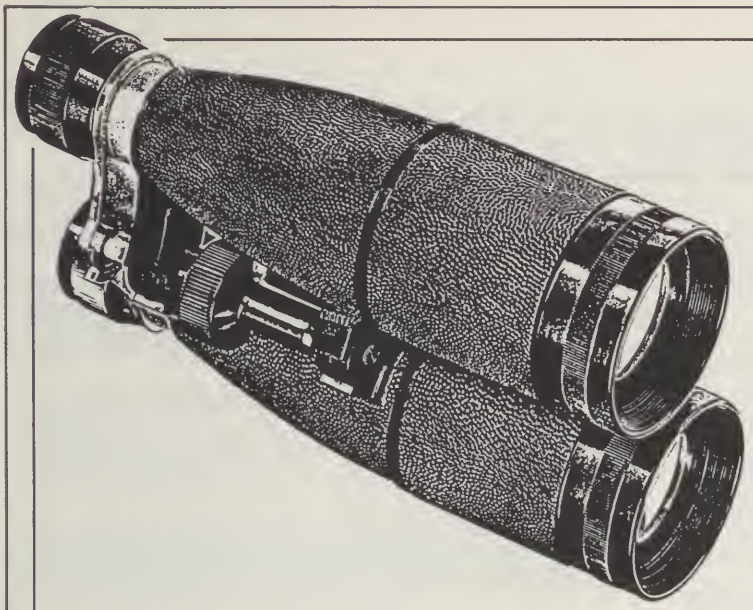

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LIPO-NICIN/100 mg. Each blue tablet contains: Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/250 mg.** Each yellow tablet contains: Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000	**LIPO-NICIN/300 mg.** Each timed-release capsule contains: Nicotinic Acid .....300 mg. Ascorbic Acid .....150 mg. Thiamine HCL (B-1) .... 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCL (B-6) ... 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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*ACC—Amer. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md.**
ACGP—Amer. Coll. of Gen. Practitioners in Osteo. Med. & Surg., Suite 1940, 111 W. Washington St., Chicago, Ill. 60602.
*ACP—Amer. Coll. of Phys., 4200 Pine St., Philadelphia 19104**
*AHA—Amer. Heart Assn., Pa. Affiliate, P.O. Box 2435, Harrisburg 17105**
*AMA—Amer. Med. Assn., 535 N. Dearborn St., Chicago, Ill. 60610**
*Chestnut Hill—Chestnut Hill Hosp., 8835 Germantown Ave., Philadelphia 19118**
*Clin. Path.—Pa. Assn. of Clin, Path., 1735 W. Main St., Norristown 19401**
*Coatesville VA—Coatesville Vet. Admin. Hosp., Coatesville 19320**
*Conemaugh—Conemaugh Valley Memorial Hosp., 1086 Franklin St., Johnstown 15905**
*Delaware Co.—Delaware Co. Mem. Hosp., Lansdowne Ave., Drexel Hill 19026**
*Dermatology—Pa. Acad. of Dermatology, 8220 Castor Ave., Philadelphia 19152 (c/o Charles H. Greenbaum, M.D.)**
*Einstein/North—Albert Einstein Med. Cntr./Northern Div., York & Tabor Rds., Phila. 19141**
*Elwyn—Elwyn Institute, 111 Elwyn Rd., Elwyn 19063**
*Geisinger—Geisinger Med. Cntr., Danville 17821**
*Hahnemann—Hahnemann Med. Coll., 230 N. Broad St., Philadelphia 19102**
*Harrisburg—Harrisburg Hosp., Harrisburg 17101**
M. S. Hershey—Pa. State Univ. Coll. of Med., M.S. Hershey Med. Cntr., Univ. Dr., Hershey 17033
*Institute— Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139**
*Jefferson—Jefferson Med. Coll., 1025 Walnut St., Philadelphia 19107**
*Lebanon VA—Lebanon Vet. Admin. Hosp., Lebanon 17042**
*Lehigh AHEC—Lehigh Valley Area Health Ed. Cntr., 17th & Chew Sts., Allentown 18102**
*MCP—Med. Coll. of Pa., 3300 Henry Ave., Philadelphia 19129**
*Mercy/Pgh.—Mercy Hosp., Pride & Locust Sts., Pittsburgh 15219**
*Norristown State—Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19141**
*Packer—Robert Packer Hosp., Sayre 18840**
*PAFP—Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111**
*Paoli—Paoli Mem. Hosp., Paoli 19301**
*PAO&O—Pa. Acad. of Oph. & Otol., 232 N. 5th St., Reading 19601**
PMS—Pa. Med. Society, 20 Erford Rd., Lemoyne 17043
*Radiology—Pa. Radiological Soc., 20 Erford Rd., Lemoyne 17043**
*Reading—Reading Hosp., 6th Ave. & Spruce St., Reading 19602**
*St. Margaret—St. Margaret Mem. Hosp., 265-46th St., Pittsburgh 15201**
*Temple—Temple Univ. Sch. of Med., 3400 N. Broad St., Philadelphia 19140**
*U. of Pa.—Univ. of Pa. Sch. of Med., 288 Med. Labs. Bldg., Philadelphia 19104**
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In most cases each of the following continuing medical education activities has been granted AAFP and ACGP (Osteopathic) credit. Contact those offices for details.

CME PROGRAMS

Listed below are programs of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, the instructor, the frequency of sessions, fees, maximum registration, etc., contact the director at the address given in the course listing or in the CODE KEY box.

Altoona Hospital; March 7 - June 6, 1974
(1) Postgraduate Seminars for Physicians; by **M.S. Hershey.** Contact: Ray Snyder, Area Dir., M.S. Hershey.

Chester; Sept. 11, 1973 - May 28, 1974
(1) Medical Seminars; by **Hahnemann;** at Crozer-Chester Medical Center. Contact: James E. Clark, M.D., Chief, Dept. of Med., Crozer-Chester Med. Cntr., 15th & Upland Av., Chester.

Harrisburg; **Harrisburg;** '73-'74 Academic Year
(1) Continuing Education for Internists and Family Practitioners; Tuesdays
(1) Staff Continuing Education; 2nd Tuesdays
(1) Current Pediatrics; at Polyclinic Hosp; Mar. 14, 1974
(1) Hematology for the Practicing Physician (by Polyclinic Hosp.); Apr. 25, 1974.
Contact: Thomas F. Fletcher, M.D., Dir. Med. Affairs, Harrisburg.

Hershey: **M.S. Hershey;** '73-'74 Academic Year
(1) Evenings in Cardiology; 1st Wednesdays
(1) Family & Community Medicine; Tuesdays
(1) Emergency Medicine; Tuesdays
(1) Endocrinology and Reproductive Biology; Wednesdays
(1) Medical Grand Rounds; Thursdays
(1) Neurology- Neurosurgery Grand Rounds; Saturdays
(1) Obstetrics and Gynecology Grand Rounds; Saturdays
(1) Pathology Study Group; 2nd Wed.; by Tri-County Pathology Assoc.
(1) Pediatrics Grand Rounds; Thursdays
(1) Pediatric-Pathology Conference; 2nd Fridays
(1) Neonatal Teaching and Pathology Rounds; Tuesdays
(1) Psychiatry Grand Rounds; 1st & 3rd Thursdays
(1) Radiology Grand Rounds; 1st & 3rd Thursdays
(1) Surgery Grand Rounds; Saturdays
(1) TB '74; Mar. 13-14, 1974 (cosponsored by Pa. Thoracic Soc. & Dept. of Public Health
Contact: Ray A. Snyder, Area Director, Dept. of Cont. Med. Educ., M.S. Hershey.

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(1) Physician-Resident Exchange Program; 1st - 30th each month.
Contact: Robert L. Bauer, M.D., Dir., Dept. of Family & Community Med., M.S. Hershey.

Hunlock Creek; Mar. 14 - May 23, 1974
(1) Postgraduate Seminars for Physicians; by **M.S. Hershey;** at Retreat State Hosp., Contact: Ray A. Snyder, Area Dir., M.S. Hershey.

Jeannette: Nov. 27, 1973 - June 25, 1974
(1) Continuing Education for Physicians; by **Pitt;** at Jeannette District Memorial Hospital. Contact: Abol Pourhamidi, M.D., Coordinator of Med. Educ., Jeannette District Mem. Hosp., Jeannette 15644.

Kane; Oct. 16, 1973 - May 21, 1974
(1) Continuing Education for Physicians; at Valley Hunt Club; by **Pitt.** and McKean Co. Med. Soc. Contact: Elizabeth M. Cleland, M.D., 106 S. Fraley St., Kane 16735.

Lewistown Hospital; Feb. 6 - Apr. 10, 1974
Current Medical and Surgical Concepts; by Lewistown Hosp. Contact: Donald E. Basom, M.D., Lewistown Hosp., Lewistown 17044.

PLEASE NOTE: The following listings are all new listings that have been received since the last publication of "Continuing Education" in Pennsylvania Medicine. Listings from the October and December 1973 editions and the January 1974 edition need to be integrated with the following to give a complete calendar.

McKeesport Hospital; Jan. 16 - March 6, 1974.
(1) Continuing Education for Physicians; by **Pitt.** Contact: Rudolph L. Buck, M.D. McKeesport Hosp., Fifth Ave., McKeesport 15132.

New Castle; Dec. 12, 1973- May 8, 1974
(1) Continuing Education for Physicians; at St. Francis Hosp.; by **Pitt.** Contact: Frank J. Altomare, M.D., Dir. of Cont. Educ., St. Francis Hosp., So. Mercer at Phillips, New Castle 16101.

Philadelphia; Eastern Pa. Psychiatric Institute; '73 - '74 Academic Year
(1) Family Therapy; An Introduction; by **MCP;** Apr. 4 - May 2, 1974 Contact: Geraldine DePaula, M.D., Dir. of Cont. Med. Educ., E.P.P.I., Henry Ave. and Abbottsford Rd., Philadelphia 19129.

Pittsburgh; **Pitt:** '73 - '74 Academic Year
(1) Cardiac Auscultation and Examination; Jan. 28 - Feb. 25, 1974; at Presby-Univ. Hosp.
(1) Continuing Education in Surgery; Jan. 7 - May 16, 1974.
Contact: William M. Cooper, M.D., Dir. Div. of Cont. Educa., Pitt.

Pittsburgh; Suburban General Hospital; Feb. 20 - June 19, 1974
(1) Continuing Education for Physicians; by **Pitt.**; in cooperation with St. John's General Hospital. Contact: Wayne Greenburg, M.D., Suburban Gen. Hosp., S. Jackson Ave. Pittsburgh 15202, or R.J. Wojciak, D.O., St. John's Gen. Hosp., 3339 McClure Av., Pittsburgh 15212.

Pittsburgh; **St. Margaret Mem. Hosp.**; '73 - '74 Academic Year
(1) Cardiology Conferences; Dec. 5, 1973 - July 19, 1974.
(1) Postgraduate Psychiatry Seminars; Feb. 26 - May 28, 1974.
Contact: Paul W. Dishart, M.D., Dir., Med. Educa., St. Margaret.

COURSES

Pittsburgh; Suburban General Hospital; Sept. 19, 1973 - June 19, 1974
(1) Continuing Education for Physicians; by **Pitt.**; in cooperation with St. John's General Hospital. Contact: Wayne Greenburg, M.D., Suburban Gen. Hosp., S. Jackson Ave., Pittsburgh 15202.

Pittsburgh; Western Psychiatric Institute & Clinic; '73 - '74 Academic Year
(1) Guest Lecture Series; by **Pitt.**, Thursdays (bi-weekly)
(1) Educational Conference; by **Pitt.**, Fridays
(1) Staff Conference; by **Pitt.**; Mondays
Contact: Daniel Small, Conference Coordinator, W.P.I.C., 3811 O'Hara St., Pittsburgh 15261.

Reading; Mar. 27 - June 26, 1974
(1) Postgraduate Seminars for Physicians; by **M.S. Hershey;** at St. Joseph's Hosp. Contact: Ray Snyder, Area Dir., M.S. Hershey.

Wilkes-Barre; At Mercy Hosp.; '73 - '74 Academic Year
(2) Neurological Emergencies, Diagnoses and Treatment; Mar. 7, 1974.
(2) Practical Application of Nuclear Medicine in the Specialty of Family Practice; Apr. 24, 1974.
(1) Current Concepts on Use of Female Hormones in Family Practice, by **Jefferson;** May 9, 1974.
Contact: J.P. Brennan, M.D., D.M.E., Mercy Hosp., 196 Hanover St., Wilkes-Barre 18703.

ADMINISTRATIVE MEDICINE

Mar. 13, 1974; Philadelphia
(2) Seminar on Licensure and Health Manpower; by Hosp. Educ. & Research Fndt.; at Holiday Inn, City Line Blvd., Philadelphia. Contact: William J. Rose, Hosp. Educ. & Research Fndt. of Pa., 1200 Camp Hill By-pass, Camp Hill, Pennsylvania 17011.

ANESTHESIOLOGY

Apr. 20, 1974; Philadelphia
(1) Subjects of Current Interest in the practice of Anesthesia; at **MCP.** Contact: Gerald Escovitz, M.D., Assoc. Dean, MCP.

May 10 - 12; 1974; Seven Springs
(1) Pa. Society of Anesthesiologists (Annual Meeting); by **Pitt;** at Seven Springs Mt. Resort. Contact: Exec. Secy., Pa. Soc. of Anesth., 20 Erford Rd., Lemoyne 17043.

FAMILY MEDICINE

Feb. 3, 1974; Pittsburgh
(1) The Many Faces of Alcoholism-Physical Disease Mimicry; at **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

GENERAL MEDICINE

Feb. 28, 1974; Philadelphia
(1) Medical Care Evaluation Seminar; by **Pitt** and Hospital Utilization Project; at Holiday Inn, City Line Ave. Contact: Hospital Utilization Project, 400 Penn Center Blvd., Pittsburgh 15235.

Mar. 28, 1974; Harrisburg
(1) Medical Care Evaluation Seminar: by **Pitt** and Hospital Utilization Project; at Host Inn. Contact: Hospital Utilization Project, 400 Penn Center Blvd., Pgh. 15235.

May 2 - 4, 1974; St. Davids
(2) Current Concepts in Medicine for the Practicing Physician; by Bryn Mawr Hosp., at St. Davids Inn. Contact: Harold J. Robinson, M.D., Bryn Mawr Hosp., Bryn Mawr 19010.

INTERNAL MEDICINE

Sept. 27-28, 1974; Pittsburgh
(1) Tri-State Meeting of the **American College of Physicians;** at **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

OPHTHALMOLOGY AND OTOLARYNGOLOGY

Aug. 5-9, 1974; Pittsburgh
(1) Management of Retinal Detachment; at **Pitt.** Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

PHYSICAL MEDICINE AND REHABILITATION

Apr. 20, 1974; Pittsburgh
(2) Symposium on Dantrolene; at St. Francis Gen. Hosp. Contact: Mr. Robert Chubon, Asst. to Med. Dir., St. Francis Gen. Hosp., 45th St. off Penn Ave., Pittsburgh 15201.

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Ronald J. Mattson, M.D., 62 Oakford Rd., Wayne 19087.
Leon Miller, M.D., 1245 Highland Ave., Abington 19001.
Conrado J. Miranda IV, M.D., 859 Old Lancaster Rd., Bryn Mawr 19010.

MONTOUR COUNTY:

Lawrence S. Greenfield, M.D., Geisinger Medical Center, Danville 17821.
John M. Miller III, M.D., Henry Ford Hospital, Detroit, Michigan 48202.
Roger W. Rodgers, M.D., 401 Laura Drive, No. 3, Danville 17821.
Hugh R. Williams, M.D., Geisinger Medical Center, Danville 17821.

NORTHAMPTON COUNTY:

Doo Tae Kim, M.D., Easton Hospital, Easton 18042.
Robert P. Myers, M.D., 826 Tioga Ave., Bethlehem 18018.

PHILADELPHIA COUNTY:

Antonio Colmenar, M.D., 5043 Coplay Rd., Philadelphia 19144.
Thomas E. Baker, M.D., 6146 Wayne Ave., Philadelphia 19144.
Steven J. Greenberg, M.D., Welsh Rd. and Roosevelt Blvd., Philadelphia 19114.
Wolodemer W. Klisch, M.D., 2931 Midvale Ave., Philadelphia 19129.
Martin Munoz, M.D., 934 Wyoming Ave., Philadelphia 19140.
Manuel B. Olympia III, M.D., 5501 N. Eleventh St., Philadelphia 19148.
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Internist, Coatesville, Pa. to work on Medical Service in accredited psychiatric Veterans Administration Hospital, 38 miles west of Philadelphia. Affiliated with Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pa. License any state. Salary range $25,000 to $32,000, commensurate with training and experience. Excellent fringe benefits. Contact Chief of Staff, VA Hospital, Coatesville, Pa. 19320. Nondiscrimination in employment.

Psychiatrists or General Practitioners to work in accredited Psychiatric Veterans Administration Hospital, 38 miles west of Philadelphia. Affiliated with Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pa. License any state. Salary range $25,000 to $32,000, commensurate with training and experience. Excellent fringe benefits. Contact Chief of Staff, VA Hospital, Coatesville, Pa. 19320. Nondiscrimination in Employment.

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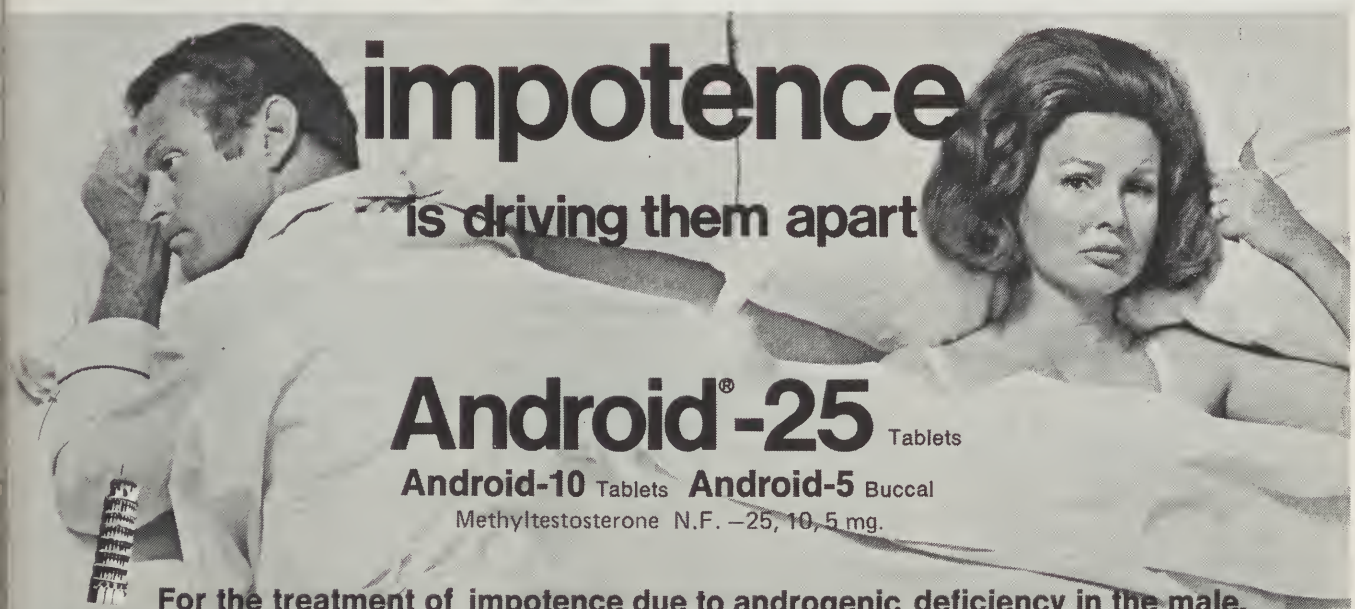

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For the treatment of impotence due to androgenic deficiency in the male.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Lyndon R. Barnett,** Bloomsburg; Harvard University School of Medicine, 1944; age 53; died December 20, 1973. He was a radiologist at the Bloomsburg and Berwick Hospitals. He is survived by his wife, his mother, two daughters, and a son.

• **Russell A. Bartruff,** Pittsburgh; University of Pittsburgh School of Medicine, 1940; age 61; died January 12, 1974. He is survived by his wife, two daughters, and a son.

• **William S. Colgan,** Pottstown; Jefferson Medical College, 1923; age 77; died January 6, 1974. No further information is available.

• **William B. Crawford,** Brownsville; Jefferson Medical College, 1916; age 82; died December 14, 1973. He was a physician in Brownsville for fifty-six years. A daughter and a son survive him.

• **Robert Denison,** Harrisburg; George Washington University School of Medicine, 1925; age 73; died December 31, 1973. He had been chief of neurology at Harrisburg Hospital for thirty-five years. He founded the hospital's epilepsy clinic and was professor of neurology and psychiatry at the school of nursing. He was a fellow of the American College of Physicians, the American Society of Internal Medicine, and a member of the American Heart Association and the American Endocrinology Society. He is survived by his wife, two daughters and a brother.

• **Isadore J. Eisenberg,** Harrisburg; Temple University School of Medicine, 1937; age 61; died December 25, 1973. He was chief of ophthalmology at Polyclinic Hospital. Dr. Eisenberg was a fellow of the American Academy of Ophthalmology and was certified by the American Board of Ophthalmology. His wife, a daughter, and a son survive him.

• **Wilbur E. Fisher,** Washington; Johns Hopkins University School of Medicine, 1933; age 67; died December 28, 1973. He was a specialist in obstetrics and gynecology. He was a fellow of the American College of Surgeons, the Pan-Pacific Surgical Society, and the International College of Surgeons. He is survived by his wife; a son; and a brother, W.K. Fisher, M.D., Meadville.

• **George R. Geeseman,** Pittsburgh; University of Pittsburgh School of Medicine, 1936; age 62; died January 3, 1974. He is survived by his wife, two daughters, and a son.

• **James R. V. Heller,** Coplay; Temple University School of Medicine, 1920; age 78; died January 4, 1974. He had practiced medicine for more than fifty years. His wife, a son, and a sister, survive him.

• **Francis O. Lamb,** Reno, Nevada; University of Chicago School of Medicine, 1938; age 62; died June 8, 1973. At one time he had been clinical professor of psychiatry at the University of Chicago School of Medicine. No further information is available.

• **William T. Leach,** Shenandoah; Jefferson Medical College, 1918; age 77; died December 28, 1973. He had been chief surgeon at Locust Mountain Hospital until his retirement in 1963. Dr. Leach was a past president of the Schuylkill County Medical Society and a member of the American College of Surgeons. He is survived by his wife; a daughter; a son; and a brother, John Leach, M.D., Shenandoah.

• **William A. Livingston,** Altoona; University of Pittsburgh Medical School, 1959; age 44; died December 26, 1973. He was a dermatologist on the staff of the Altoona Hospital. He is survived by his wife, two daughters, a son, his mother, and a sister.

• **Raymond M. Price,** Bradford; Georgetown University School of Medicine, 1935; age 71; died December 28, 1973. He is survived by his wife, two daughters, two sisters, and three brothers.

• **Joseph C. Sieracki,** Pittsburgh; University of Buffalo School of Medicine, 1951; age 48; died November 14, 1973. He was a fellow of the College of American Pathologists, the American Society of Clinical Pathologists, the International Academy of Pathology, and the American Society of Hematology. His wife, two sons, and two daughters survive him.

• **Joseph B. Sofranko,** Jim Thorpe; Temple University School of Medicine, 1935; age 64; died November 12, 1973. He was formerly chief of medicine at Gnaden Huetten Hospital, Lehighton, and was a cardiologist. He is survived by three sisters and three brothers.

• **William C. Troxell,** Hazleton; Medico-Chirurgical College, Philadelphia, 1908; age 89; died November 2, 1973. He was a former chief radiologist at Allentown Hospital and was a fellow of the American College of Radiology. His wife, a sister, and two stepsons survive him.

• **Joseph G. Weiner,** Meadowbrook; University of Pennsylvania School of Medicine, 1922; age 75; died December 31, 1973. He had served for more than forty years on the staff of Albert Einstein Medical Center, Northern Division. Dr. Weiner was a fellow of the American College of Physicians and was certified by the American Board of Internal Medicine. He is survived by his wife and two daughters.

• **Louis Weiss,** Sewickley; University of Pittsburgh School of Medicine, 1925; age 70; died December 7, 1973. He was certified by the American Board of Otolaryngology and was a fellow of the American Academy of Ophthalmology and Otolaryngology and of the American College of Surgeons. He is survived by his wife and a daughter.

Crawford J. Best, Leesport; University of Toronto Medical College, 1927; age 77; died January 6, 1974. His wife, two daughters, a son, and a sister survive him.

John Hipsky, Clairton; University of Pittsburgh Medical School, 1966; age 33; died December 12, 1973. He was chief of medical services for C. Howard Marcy State Hospital. Information regarding survivors is not available.

Joel A. Laster, Philadelphia; Medical College of Virginia, 1967; age 33; died November 6, 1973. Dr. Laster was a radiologist. No information regarding survivors is available.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 1000. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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HE385A

pennsylvania medicine

APRIL 1974

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medigram April 1974

BULLETIN! FOUNDATION FUNDED

HEW has awarded a contract of $243,295 to the Pennsylvania Medical Care Foundation for the development of a Peer Review Advisory Center, Matthew Marshall, Jr., M.D., Foundation president, announced March 31. The center, a national first, will provide organizational and technical assistance to local PSROs and hospital medical staffs, Larry Fosselman, Foundation executive director, said. It will continue work already begun by the Foundation. Details will appear in the May issue.

MEDICAL CO-OP DRIVE ON The Pennsylvania Medical Cooperative membership drive was formally launched when Ralph C. Wilde, M.D., Society president, purchased the first $100 share in the cooperative. A letter of explanation from Dr. Wilde and a cooperative membership application were mailed to all Society members at the end of March. The Council on Public Service has prepared a slide show explaining the cooperative, but advance reservations are needed because of heavy bookings. Contact L. Riegel Haas, acting director of professional relations, to make arrangements. The Council also will be making direct contact by telephone to members urging them to join the cooperative.

BOARD REVIEWS CERTIFICATE OF NEED POLICY Acting on a recommendation of the Council on Medical Service, the Board of Trustees at its March meeting gave support in concept to certificate of need legislation as outlined in Section 1122 of Title XI of the Social Security Act (Section 221 of Public Law 92-603) which provides financial penalties for hospitals not complying with state comprehensive health planning. The Board supported in the same action a recommendation of nonsupport of state legislation which could include injunctive powers. The Board further voted to support a recommendation that where there exists a conflict between the state planning agency (314a) and a local agency (314b), a hearing be held at the local level on the dispute. The Board reiterated its previous position opposing the concept of a fiscal agent acting as a review agency for comprehensive health care planning.

COMPREHENSIVE HEALTH CARE ACT TESTIMONY GIVEN Hearings were held in March on S.B. 1326, the "Comprehensive Health Care Act," at several locations in the Commonwealth by the Senate Health and Welfare Committee. The Society's testimony was presented in Pittsburgh on March 14 by Robert J. Carroll, M.D., member of the Council on Governmental Relations. Dr. Carroll told the committee that the Society's House of Delegates at its 1973 Annual Session had gone on record as opposing S.B. 863, the Administration's Comprehensive Health Care Act of 1973, because "it imposed unusual and extremely burdensome regulations not only on hospitals, but on physicians and others." Although S.B. 1326 is a so-called compromise bill, Dr. Carroll pointed out to the committee that the Society's Board of Trustees had acted to support legislation containing three main ingredients--certificate of need, authorization of the Department of Health to license hospitals, and uniform accounting procedures for hospitals. He called on the committee to amend S.B. 1326 to cover these three main issues and said several sections are objectionable, especially those requiring state approval of rates paid to providers and approval of contracts between providers and third-party payors. Dr. Carroll also explained that Section 221 of federal Public Law 92-603 (now Section 1122 of Title XI of the Social Security Act) makes questionable the need for further state legislation to establish a health planning board. The May issue of PENNSYLVANIA MEDICINE will carry a detailed article on S.B. 1326.

SOCIETY TESTIMONY CITES CONFLICTS In testimony given at hearings conducted during the last week in March, the Society told the House Health and Welfare Committee that recently introduced H.B. 2018, the "Health Care Facility Cost Containment Act," might be unnecessary legislation. The bill would give the Department of Health certain cost control power over hospitals and would establish another advisory council. John F. Rineman, the Society's executive vice president, presented testimony explaining that while physicians become "frustrated, just as have legislators, in grappling with hospital costs," it is important to examine what currently is on the books in the way of legislation and regulations to control costs in order to avoid enacting counterproductive legislation and to have time to evaluate present laws concerning cost containment. Particularly cited with respect to additional certificate of need legislation was Section 221 of Public Law 92-603 (Section 1122 of Title XI of the Social Security Act). The Society's testimony questions the need for further legislation on comprehensive health planning in view of the control which now exists through federal legislation. The Society called attention to the PSRO section of Public Law 92-603 as another means of cost control and explained the Pennsylvania Medical Care Foundation's Certified Hospital Admissions Monitoring Program (CHAMP) and the role it might play in the law's implementation.

LEGAL COUNSEL OPINION SUPPORTS BOARD POLICY The Society's legal counsel, Fred Speaker, Esq., has issued a legal opinion stating that hospitals cannot require physicians to carry professional liability insurance as a prerequisite to appointment to a hospital medical staff. He states: "It would be improper for a hospital to attempt to require coverage through such coercive tactics." The opinion supports a policy set by the Board of Trustees when it voted in March to encourage members of hospital medical staffs to carry professional liability insurance but to oppose requirement of insurance as a prerequisite for staff privileges. Speaker's opinion said such a regulation improperly delegates to someone other than the hospital--that is, the insurance carrier--the effective determination of which physicians will be admitted to staff privileges.

PSRO CONTRACT APPLICATIONS BEING ACCEPTED The Department of Health, Education, and Welfare has announced it is accepting applications for contracts from physician organizations seeking to participate in the Professional Standards Review Organization (PSRO) program. Initial deadline for submission of proposals for planning contracts had been April 15, 1974, but the deadline has been extended to April 30 at the urging of the Pennsylvania Medical Care Foundation and other interested parties. Requests for contract applications and for copies of the PSRO Manual must be in writing from the Contracting Officer, Health Services Administration, Room 16-A-30, 5600 Fishers Lane, Rockville, Md. 20852. Twelve geographic areas have been established in Pennsylvania by the publication of final HEW regulations. In seven of these, physician organizations have plans to submit contract proposals to date. They are in areas two, four, six, seven, eight, nine, and twelve. The Pennsylvania Medical Care Foundation is advising local organizations in PSRO matters as mandated by the House of Delegates.

NEW CHARGE GIVEN TO MEDICINE-RELIGION COMMITTEE The Board approved new objectives for the Committee on Medicine and Religion. Included is study of such matters as definition of death, euthanasia, behavior modification, genetics, and human medical experimentation. In

other action the Board voted to increase the number of its meetings from five to six each year; approved the recommendation of the Interspecialty Committee that committee membership and representation at the House of Delegates be extended to the Robert H. Ivy Society (Plastic Surgery); heard a report that voluntary contributions to the Quackery Defense Fund to date amount to $16,500 with about 50 percent of members participating; and approved presenting the Benjamin Rush Award for an individual to Mrs. Richard Rollins, of Haverford, for her work as a braillist--and for a group to the Clearfield Children's Aid Society. Awards will be presented at the Annual State Dinner in October.

SOCIETY REPRESENTED AT ACUPUNCTURE HEARINGS Informal hearings on acupuncture conducted by Louis P. Vitti, commissioner for professional and occupational affairs, were held March 19 and 20 in Philadelphia, March 21 in Harrisburg, and March 22 in Pittsburgh. The State Society, along with the Allegheny and Philadelphia County Medical Societies, arranged for testimony from physicians despite short notice. Physicians testifying included the following: Teruo Matsumoto, M.D., Ph.D., Philadelphia, professor of surgery at Hahnemann, who has been conducting acupuncture research for two years; Nathan Sussman, M.D., Harrisburg, member of the Society's Council on Education and Science; Allen E. Yeakel, M.D., Hershey, chairman of the medical center's department of anesthesiology; Ray McKenzie, M.D., Pittsburgh, head of anesthesiology at Magee-Womens Hospital; Ruben Tenicela, M.D., Pittsburgh, associate professor of anesthesiology and director of the pain clinic at Presbyterian University Hospital, who also conducts a clinical research program in acupuncture; and Alfred Tung, M.D., recently of Hong Kong, Dr. Tenicela's associate. Fred Speaker, Esq., the Society's legal counsel, testified that acupuncture should be governed by licensing boards of doctors of medicine and of osteopathic medicine. Dr. Matsumoto and Bruce A. Levy, M.D., fellow in surgical research at Hahnemann, have authored a special report for PENNSYLVANIA MEDICINE (see page 30) on the history of acupuncture and their current research. Commissioner Vitti said he plans to issue guidelines to control acupuncture. Chiropractors appeared in large numbers at all of the hearings but were divided on whether or not they should be permitted to practice acupuncture.

ACUPUNCTURE RESEARCH SPARCE IN COMMONWEALTH The last published position of the State Board of Medical Education and Licensure on acupuncture is that the procedure is the practice of medicine and that: "In Pennsylvania this procedure has not been researched nor proven beneficial. It is the Board's opinion that patients who have been properly examined, diagnosed, and considered for acupuncture therapy could receive same after referral by a physician to a research setting in a medical school under the guidance of a duly licensed and registered physician in the Commonwealth." The Society's Board of Trustees at its March 13 meeting supported this position of the state board. However, a recent survey made by the State Society shows that of the state's seven medical schools, two have no program in acupuncture, and the others are limited. At Temple the Pain Clinic, under the direction of Leroy W. Krumperman, M.D., professor and chairman of the department of anesthesiology, does some acupuncture. Jefferson has no formal program but hopes to expand its acupuncture activities through the Pain Control Service under the direction of James Erickson, M.D., professor of anesthesiology. At the University of Pennsylvania School of Medicine, some acupuncture is done through the Center for Control of Pain under the direction of Alan Ominsky, M.D. At the University of Pittsburgh School of Medicine, some acupuncture is done through the Pain Clinic, headed by Dr. Tenicela. At Hahnemann,

the Department of Surgical Research does some acupuncture under the direction of Dr. Matsumoto. All programs are limited in the number of referrals which can be accepted.

WORKMEN'S COMPENSATION PAYROLL AUDITS DUE Within the next sixty days, field payroll auditors of Casualty Reciprocal Exchange will be calling on those of you who have placed your insurance with that organization. Your cooperation in having the necessary records available for completion of the audit will be appreciated. The sooner the audits are made, the sooner Dodson Insurance Group can calculate the earned savings for the past year and make the necessary distribution. In case you have been asked to provide a voluntary report instead, you can help in reaching an early determination of savings by returning the requested information as promptly as possible.

INSURANCE COMMISSIONER NAMED Pennsylvania has a new insurance commissioner, pending Senate approval. He is 37-year-old career civil servant, William J. Sheppard, who has been serving as a deputy commissioner in the department. He replaced Herbert S. Denenberg, Ph.D., who resigned effective March 29 to seek the Democratic nomination for U.S. Senator.

IMMUNIZATION BILLS GO TO GOVERNOR Three Society-supported bills on immunization passed the Senate March 26 and two were sent to the Governor for his signature. House Bills 1363 and 1364 permit the Secretary of Health, with the advice of the Advisory Health Board, to issue rules and regulations on communicable diseases and immunization for school children. H.B. 1365, which gives legal protection to physicians and nurses participating in approved mass immunization programs, was returned to the House for concurrence in Senate amendments.

DR. SAMMONS CHOSEN FOR TOP AMA POST James H. Sammons, M.D., of Baytown, Tex., who has been chairman of the AMA Board of Trustees, was elected to the post of executive vice president by the Board of Trustees at its March meeting. He succeeds the retiring Ernest B. Howard, M.D. and will join the AMA staff April 1. The family physician was succeeded as chairman of the AMA Board of Trustees by Richard E. Palmer, M.D., who has served as vice chairman since last fall. Dr. Palmer is chairman of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals.

STATE BOARD CALLS FOR NOTIFICATION Doctors of Medicine who did not receive their 1973-74 registrations from the State Board of Medical Education and Licensure are being requested to contact the board immediately notifying it of their present addresses. Send the information to the Secretary, State Board of Medical Education and Licensure, 279 Boas St., Harrisburg, Pa. 17120.

SOCIETY INCREASES MILEAGE FEE The mileage fee for officers and members of the State Society driving on Society business has been increased to 15 cents per mile in action taken by the Board of Trustees.

COLC MAKING SPOT CHECKS Cost of Living Council officials are spot-checking Pennsylvania physicians' offices to see if Phase IV signs are posted and if fee schedules are available. A number of Lehigh Valley physicians were visited in recent weeks.

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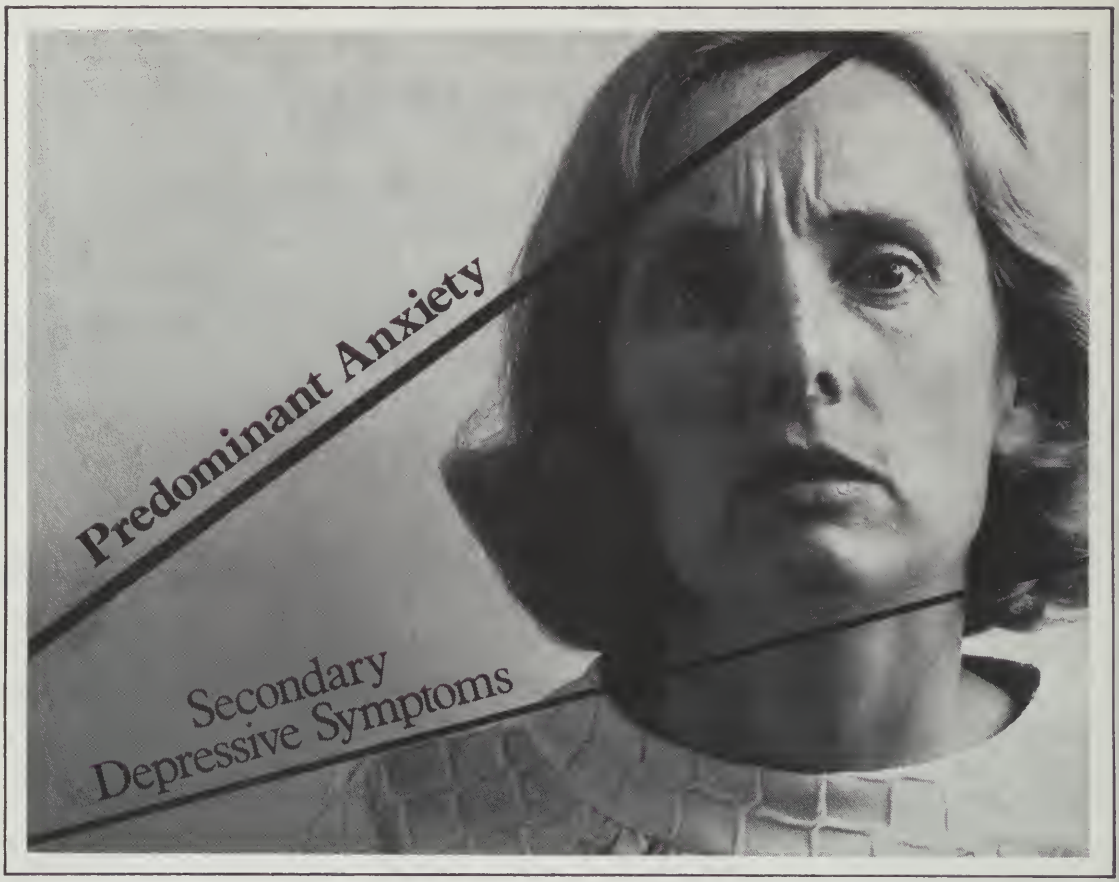

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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1. *See the supplement to JAMA, August 13, 1973.*
   Attendance at any listed course may be reported on an hour-for-hour basis in Category I.
2. *See PENNSYLVANIA MEDICINE, October and December 1973 and January and March 1974.*
   Category I credit activities are marked (1).
3. *See list of Pennsylvania accredited continuing medical education institutions on page 21, December 1973 PENNSYLVANIA MEDICINE.*

   or

   See the brochure accompanying the 1973 application form for the AMA Physician's Recognition Award. Beginning on page 9 is a complete list of accredited institutions nationwide.
   Continuing medical education activities of these institutions generally carry Category I credit.
4. *Call the organization that is sponsoring the program. Ask (a) if Category I credit has been authorized for the program and (b) who the accredited sponsor is.*
   You will need this information for the PRA application form.

For more information, contact: Council on Education and Science
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Officers' Conference April feature

Is there a shortage of physicians in Pennsylvania? Specifically, is there a shortage of primary care physicians? These questions and others will be answered by a panel of experts at the 1974 Officers' Conference, which opens at 2 p.m., Wednesday, April 24, at the Harrisburg Host Inn.

This first panel discussion, entitled "Unraveling the Distribution Knot—Primary Care," will follow opening remarks by the conference chairman, R. William Alexander, M.D., of Reading, and a "Report to the Stockholders," detailing the Society's progress since the 1973 session of the House of Delegates, by John F. Rineman, executive vice president.

The primary care panel discussion will be led by four speakers. Bernard B. Zamostien, M.D., of Philadelphia, will represent the American Academy of Family Physicians. He is a past president of the Pennsylvania Academy of Family Physicians.

Representing medical schools on the vital issues of curriculum and curriculum reform will be Paul C. Brucker, M.D., chairman of the department of family medicine at Jefferson Medical College and director of the family medicine residency program scheduled to begin operations in September of 1974.

Panelist Samuel B. Watterson, M.D., a family physician from Boswell, Somerset County, where he maintains a rural practice with his partner, Jan R. de Vries, M.D., will speak on the impact of adding physician's assistants to their practice when a physician in a nearby town moved away, leaving this segment of the population to their care.

Representative William R. Shane, legislator from Indiana County and cosponsor of H. B. 1550, which proposes new ideas for subsidizing medical education in the Commonwealth, will round out the panel. Shane, a Democrat, was born in Indiana, Pa., graduated from Harvard in 1957, and earned his law degree from the University of Pennsylvania in 1961.

H.B. 1550, which the Society supports in principle, would establish a Pennsylvania Medical Education Council to set medical education priorities and responsibilities, particularly for postgraduate training, and would earmark state funds accordingly.

The Pennsylvania Medical Political Action Committee (PaMPAC) has prepared the final portion of the Wednesday afternoon session, featuring two nationally known speakers. They are Rex E. Kenyon, M.D., of Oklahoma City, a member of the AMPAC Board of Directors, and Paul M. Newman, of Diamond Bar, Calif., political analyst and head of his own research organization. Newman will explain how analyses are used by candidates to determine the critical issues in a campaign and the image they should project to win votes. Dr. Kenyon will discuss AMPAC strategy in election year 1974.

Continuing education and the Society's education requirement for continued membership will be highlighted at the Thursday morning session, featuring expert speakers from the AMA and on the state level.

Final speaker for the two-day program will be Charles M. Jacobs, J.D., associate director of the Joint Commission on Accreditation of Hospitals. Jacobs, who did his undergraduate studies and took his law degree at the University of Chicago, is responsible for the office of legal affairs and for professional relations for the commission and is an instructor at the University of Missouri School of Medicine. His subject is: "Medical Staff Law and Bylaws—Myth, Rumor, and Fact."

Reye's syndrome study involves Pittsburgh physicians

Children's Hospital of Pittsburgh cared for twenty-three of the twenty-four patients suffering from Reye's syndrome who were the subject of a study reported in an article in the March 1974 issue of *Pediatrics* (official publication of the American Academy of Pediatrics.)

The children ranged in age from two months to thirteen years. Those treated with peritoneal dialysis in addition to standard therapy had an 82 percent recovery rate, while those treated with standard therapy alone had only a 15 percent recovery rate. In all cases, the patient had had a mild viral-type infection about a week prior to the onset of repetitive vomiting, delirium, disorientation, or seizures followed by coma.

The paper was coauthored by Frederick J. Samaha, M.D., U.S. Public Health Service; and Edward Blau, M.D. and John Berardinelli, M.D., from the departments of pediatrics and neurology at the University of Pittsburgh School of Medicine and Children's Hospital of Pittsburgh.

Society to hold management seminar

A workshop on medical practice management will be presented on May 10-11 by the PMS Continuing Education Program at the Hershey Motor Lodge, Hershey, to assist physicians in the improvement of the management of both individual and group practices.

The faculty is comprised of four experts in the application of sound business principles and systems of organization directly applicable to the setting up of new medical practices or the improvement of existing ones.

Leif C. Beck, LI.B., president of Management Consulting for Professionals, Inc., Bala Cynwyd, has become familiar to Pennsylvania physicians through his series of articles in PENNSYLVANIA MEDICINE. He is a member of the Society of Professional Business Consultants, an editorial consultant for *Medical Economics*, and is a lecturer on medical management, taxation, and professional corporations.

Roger Harrison, C.P.B.C., owner of Roger Harrison Associates, Inc., Norman, Oklahoma, is past president and chairman of the board of examiners of the Society of Professional Business Consultants. He is an editorial consultant for *Medical Economics* with seventeen years experience as a business consultant for physicians.

Fred Speaker, Esq., a partner of the law firm of Pepper, Hamilton and Scheetz, is former director of the Legal Services Program for the Office of Economic Opportunity in Washington, D.C., former attorney general for the Commonwealth, and legal counsel for the State Society.

Thomas E. Zirkle, C.P.B.C., co-owner of Professional Management Associates, Inc. of Chicago, Ill. and Denver, Colo., is immediate past president of the Society of Professional Business Consultants, a contributing author to *Prism* (the new AMA magazine), and is the author of the book entitled *Corporate Practice*.

See the announcement in this issue of PENNSYLVANIA MEDICINE (page 6) for specific areas applicable to all solo and group practice management, for Category One credit allowable, and for registration details. Further information may be obtained by contacting the PMS Registrar, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, Pa. 17043. Advance registration is necessary.

Renal disease committee members named

Three new physicians have been named to two-year terms on the governor's Renal Disease Advisory Committee, Secretary of Health J. Finton Speller, M.D., announced recently.

They are: Edward S. Cooper, M.D., Germantown; Joseph J. Mowad, M.D., Danville; and Mario J. Sebastianelli, M.D., Jessup. Committee members who were reappointed to the committee include Drs. J. D. Lasher, Erie; James A. Nicotero, Pittsburgh; Bradford K. Strock, Mechanicsburg; and Frank J. Sweeney, Bala Cynwyd.

One of the committee's responsibilities is to regulate state-approved treatment centers for patients suffering from chronic kidney disease. There are currently some 543 Pennsylvania residents being treated at thirty-three such hospital centers, according to George A. Jones, M.D., director of the Chronic Renal Disease Services.

Three groups announce annual meetings

The Wainwright Tumor Clinic Association's annual meeting will be held on May 8, 1974, at Shadyside Hospital in Pittsburgh, Whitney C. Corsello, M.D., president, has announced.

A.S. Ketchum, M.D., National Cancer Institue surgeon; Robert J. Hartzog, M.D., Singer Memorial Research Institute of Pittsburgh pathologist and researcher; Richard Desser, M.D., Michael Reese Hospital, Chicago; and Joseph H. Burchenall, Memorial Hospital of New York City chemotherapist, will present the cancer oriented program. All physicians are welcome to attend the meeting which will begin at 9 a.m.

The annual meeting of the Pennsylvania Society of Anesthesiologists will occur May 10-12 at Seven Springs Mountain Resort, Champion.

Anesthesia and its relation to endocrine, neurosurgical, pediatric, and cardiopulmonary problems will be discussed during the scientific sessions. A seminar on malpractice loss prevention sponsored by Argonaut Insurance Company, underwriter of the State Society's professional liability program, will be a feature of the meeting.

The annual meeting of the Pennsylvania Allergy Association will be held June 14-16, 1974, at the Hershey Hotel, Hershey. Program Chairman is Leonard S. Girsh, M.D., Philadelphia.

Topics applicable to clinical allergy will deal with immunology and pharmacology.

Medical co-op new—idea time tested

Members of the State Society received last month their initial invitation to join the Pennsylvania Medical Cooperative, a venture being sponsored by the State Society as mandated by the 1973 House of Delegates. Purpose of the cooperative, membership in which is open to State Society members only by purchase of a $100 lifetime share, is to afford physicians substantial savings in the purchase of office supplies.

The concept is simple. The cooperative will purchase supplies in large amounts directly from manufacturers at wholesale prices and resell to members at cost. Being built into the plan is an automatic replenishment feature which will maintain the office inventory of basic supplies at the level desired by the physician member.

If you've received your letter of invitation, you may be wondering at this point about the history of cooperatives in the United States and their record of service to their members.

Think about it at breakfast, while you enjoy juice, buttered toast, cereal, eggs, bacon perhaps, and coffee. You may not realize it, but a large portion of what is served at your breakfast table comes to you through cooperative enterprise of some kind. Some of the largest food producers in the nation belong to cooperatives, through which they buy supplies and market their goods.

Think about credit unions—these are cooperatives—and almost 22 million Americans use them to save money and to borrow at low interest rates when necessary. Almost eight million Americans now belong to prepaid group health plans—another form of a cooperative. Students form co-ops to provide housing and books to members at reasonable cost. Farmers have joined cooperatives over a long period of time, and for many reasons. Cooperative purchasing of supplies has saved them money. Cooperative action has provided electricity and telephone service. Cooperative marketing has enabled farmers to offer their goods to the public at reasonable prices.

Millions of Americans benefit from cooperatives. Why not you? See the announcement of the Pennsylvania Medical Cooperative on page 26 of this issue. For further information, contact the PMS Council on Public Service, 20 Erford Rd., Lemoyne 17043.

Pennsylvania MEDICAL Cooperative

Approve new residency programs in state

Additional family practice residency programs have been approved by representatives of the American Academy of Family Physicians, the American Board of Family Practice, and the American Medical Association at a December meeting of the Residency Review Committee for Family Practice.

Newly approved family practice training programs in Pennsylvania are at Latrobe Area Hospital, Latrobe; Chestnut Hill Hospital, Philadelphia; and at Thomas Jefferson University Hospital (and university affiliated hospitals), Philadelphia.

These latest approvals bring the number of such programs in the state to seventeen.

State M.D.s, students serve on S.S. Hope

Ten Pennsylvania physicians and medical students have completed two-month rotational periods of service aboard the S.S. Hope during her final six months in Maceio, Brazil. They were engaged in public health and preventive medicine programs and in teaching both undergraduate and graduate courses in medicine and surgery.

Those who have served since mid-June are: **Robert E. Johnstone,** anesthesiology resident, Aldan; **Robert J. Demuth, M.D.,** plastic surgeon, Erie; **Frank B. Diamond, Jr.,** medical student, Hershey; **Brett B. Gutsche, M.D.,** anesthesiologist, Philadelphia; **James W. Harwood,** medical student, Philadelphia; **Charles R. Bales, M.D.,** plastic surgeon, Erie, **Eric M. Kennel, M.D.,** anesthesiologist, Philadelphia; **Robert Steiner, M.D.,** radiologist, Philadelphia, **Frank M. Tooze, M.D.,** plastic surgeon, Erie; and **Theodore C. Smith, M.D.,** anesthesiologist, Philadelphia.

The HMO Act of 1973 and its meaning to private practice

LEIF C. BECK, LI.B.
Bala Cynwyd

Mr. Beck is President of Management Consulting for Professionals, Inc. of Bala Cynwyd.

The "Health Maintenance Organization Act of 1973," signed into law by President Nixon on December 29, 1973, is of importance to every private practicing physician. It thus surprises me that most of them seem not to understand what it provides and how the resulting HMOs might operate. Even more importantly, each private physician should become aware how HMOs might affect his own future.

I recently attended a two-day briefing session on the new law, sponsored by the Group Health Association of America, and I am convinced that the HMO will be a bona fide economic competitor to traditional private practices. Furthermore, considering the amount of funding assistance and certain other advantages the Act gives to HMOs, the level of competition will undoubtedly drive many doctors out of private practice. It will probably cause the remaining doctors some degree of economic disruption as well.

My statements do not, however, mean that I am opposed to HMOs or to the new Act. In fact, I believe the new arrangements might provide the public with a healthy choice between contrasting concepts of health care delivery. Such competition exists in all other segments of our society, generally to the benefit of society itself, and there is no valid reason why the same should not be true in medicine.*

As a result, I believe physicians should learn basically what is contained in this important new federal law. Some of them will consider taking the lead in forming HMOs in their own areas, hence using the Act themselves; others will consider joining HMOs or contracting to provide specialty services, perhaps even on a fee-for-service basis. In whatever capacity, I hope this series of articles on the Act and its terms will be useful.

Introductory Summary

Very briefly, the Act defines a HMO as an organization providing broad health services to its members on a "prepaid" or premium basis. There are eleven specific requirements that an HMO must meet to qualify within the Act, and these include emphases on health maintenance, quality control, and professional education, as well as encouragement of services to "medically underserved population" groups and member-patient participation in policy decisions. All of these aspects will be discussed later.

Recognizing the economic difficulty of getting an HMO into operation, the Act calls for $325 million of assistance over the next four fiscal years. These funds will be used to help support feasibility surveys, planning and initial development costs, and some initial operating costs. The assistance will be in various forms, including outright grants, contracts, loans, and loan guarantees.

In addition, the Act gives further aid to HMOs by requiring most employers to offer health benefit plans through area HMOs and by "preempting" certain state laws regarding medical practice. In my view, these latter non-dollar aspects may become the most significant.

HMO Employee Health Plans

Recognizing that the best way for an HMO to obtain its desired size* is through employee health benefit plans, Section 1310 of the Act requires use of that avenue. It provides that every employer subject to the Fair Labor Standards Act (the minimum wage laws) and having at least twenty-five employees must offer its employees a "dual choice." If there is a "qualified" HMO offering services in the area where the employees live, and if the employer offers any health benefits plan at all, it must offer the HMO arrangement as an alternative *choice*.

Since most companies have employee health programs, and since most of them are subject to the minimum wage law, the net effect of this dual

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** The risk, of course, is that general governmental regulation over private practice (such as continued wage and price controls, medicare preferences, and the like) will unduly restrict private practices in their competition with HMOs. This possibility is not implicit in the new Act and is in fact contrary to its intent to have viable alternatives. I hope government generally will respect that intent.*

** To assure extensive reach of the "dual choice" concept, the HMO Act requires it even of those employers who would be exempt from the minimum wage laws under the Fair Labor Standards Act's employee exemption provisions.*

choice provision may be dramatic. It will simply cause a great percentage of our population to be presented with the immediate and continuing opportunity to join an HMO for all medical care and concurrently cease to be patients of their former private practitioners.

The HMO's appeal to these employees and their union leaders may be far greater than most of us anticipate. The HMOs will be well-organized and promoted, with freedom from traditional medical restrictions against advertising and/or soliciting members (discussed later). Their "total health care" and "health maintenance concepts" will be most appealing sales points, which are already particularly popular among labor unions. Even company personnel managers may find HMOs to be a more attractive benefit. If only 20 percent of the employees in a community should "buy" this choice, one can well imagine the economic effect upon the established medical practices.

There are presently at least sixty-seven HMOs in practice*, and with $325 million dollars of assistance money involved, that number may become perhaps 400 in just a few years and then over 1,000. This should mean at least one active HMO in each population area, so that the pressure on private practice should become quite widespread.

Some restrictions may tend to lessen the effects described above. For example, an HMO must offer such an extensive package of merely "basic" health services that the monthly premium may make the choice too costly. And since the Act protects employers by not requiring them to pay more for health benefits through the HMO than under their prevailing programs, much of the cost may pass through to the employees themselves—making the HMO still harder to sell. While recognizing these problems, however, my own view is that they will merely delay HMO development without becoming an absolute hindrance.

Some critics in the medical establishment contend the HMOs will be unable to recruit enough doctors to meet the expansion goals. This may be a problem, yet the economics are so huge (especially when including the governmental assistance) that the HMOs should be able to compete. What is more, the Act's entire concept of fostering independence among HMOs in such matters as income division methods and patient-physician responsibility may make some HMOs far more attractive than the traditional stereotype of salaried medicine. Finally, the Act permits an HMO to contract with existing medical practices for services, even on a fee-for-service basis* if desired, and this may be the source for much of the medical manpower during the growth stage. As HMOs grow, of course, their economic pressures are likely to influence increasing numbers of private practitioners to switch.

Overriding of State Laws

Section 1311 of the Act is another potent force in fostering HMO development. It does this by cutting through or "preempting" any state statutes or regulations hindering the organization or operation of HMOs. If any state rule requires a medical care organization (1) to obtain medical society approval, (2) to have physician control, (3) to permit open physician membership, or (4) to meet certain insurance regulations, those rules are specifically made inapplicable to any HMO which is either federally "qualified" or financially assisted under the Act. This variety of state regulation had seriously impeded HMOs in some states, although Pennsylvania is no longer one of them.

The Act similarly prohibits any state from preventing an HMO from soliciting patient-members through advertising its services, charges, or other aspects. Thus, when an HMO is offered to an employee group as a new choice, the HMO may make a real *marketing* effort in much the same way as business promotes all other products and services. Many of the full-time organizers of HMOs are in fact marketing experts, indicating a relatively new dimension in the health care industry.

While the HMO and its details may be advertised, the Act is careful to prevent any advertising of the doctor himself. This is a reasonable reflection of the medical ethical rules against solicitation. Nevertheless, the traditional fee-for-service group may find it difficult to retain its patients as they become barraged by sophisticated marketing of the HMO.

Federal Financial Assistance

HMOs are so costly to bring into self-sufficiency that their development has been sketchy to date. Arrangements for hospital care, extended care facilities, specialty physicians, and the like may require a patient base of thousands before the break-even point can be reached, and the early losses could be staggering. Even preliminary studies into an HMO's feasibility could cost far

(Continued on page 15)

** This is the number presently receiving payments for medicaid services, per Lucille Reifman, associate commissioner, Medical Services Administration, Dept. of Health, Education, and Welfare.*

** There must, however, be a core "medical group" which is principally involved in the HMO practice. It is normally contemplated that this core group will render at least the bulk of the primary care.*

editorials

Give PSRO critical test

On January 24, 1974, at the midwinter session of the AMA, the House of Delegates adopted a position paper on PSRO.

The establishment of a Professional Standards Review Organization (PSRO) under federal government control became law late in 1972 as part of the Social Security Amendments of 1972.

Many recommendations and options on PSRO were discussed at the AMA meeting. In general it was quite obvious that many delegates were unhappy with PSRO, and some of the discussion centered around repeal of the legislation.

As distasteful as the Bennett Amendment is to physicians—like any law of the land, it is a reality and has become a fact of life. There is little likelihood of repeal because it must be given an opportunity to show whether the delivery of medical care will be improved under a legislatively mandated peer review organization.

The sanest approach will be to amend the law after it has been tested to eliminate those features which may contribute to the deterioration of patient care by interfering with the physician's judgment in the care of his patient.

Safeguards must be established to preserve confidentiality between physician and patient. The bureaucratic mind will attempt to implement rules and regulations designed to enhance its public image as a preserver of the public health.

It seems assured that PSRO will achieve the status of a federal government regulatory agency with state and regional offices. While the exact role remains to be defined, data acquisition, cost containment, and investigation of patient grievances against health providers could be expected to be a part of the role.

With the increasing expansion of the HMO concept and the push from our present "cottage industry" into health care corporations, one can see the gradual evolvement of the private health care system into a public utility.

In the present atmosphere of runaway inflation, we now have headlines on prices in the oil and food industries as well as on medical care. While recognizing the complexities of American business and industry and their long-standing relationships with government regulatory agencies, it hardly gives me comfort to see the continuing encroachment by federal and state government on the private sector of medical care as an answer to the so-called health care crisis. This contrived crisis has been used as the club to convince the public of the need for all sorts of government programs of health care.

It would give me great satisfaction to see a task force go to work to compare the cost and and performance of current government medical provider programs with the cost and performance of the private sector. Neither side would be without its deficiencies, but I am certain that by any measure, private medicine would receive a superior performance rating.

If we are to effect beneficial changes in the health care system, it must be with knowledgeable physicians and health care fiscal and administrative professionals already thoroughly familiar with our present system.

Above all, the government health care bureaucracy can no longer enjoy the anonymity it has had all too long. The decision making bodies must maintain a high degree of public visibility and be held publicly accountable for their actions or inaction. Organized medicine must assure the development of open lines of communications between government regulator, consumer, and provider for prompt resolution of problems if patients are to avoid being caught in a morass of government red tape to assure the medical necessity and proper level of care for their ailments.

David A. Smith, M.D.
Medical Editor

Make education count

The goal of every physician is improved patient care. The goal of any continuing education program is better health care. How to get from here to there is sometimes a problem. Many of us, at one time or another, have gone to a conference whose title was not descriptive of the program and little useful knowledge applicable to our practices was gained. This unfortunate situation can be avoided by forethought and preliminary planning.

In order to determine the program most suited to your personal needs, obtain a general overview of your practice. Collect and summarize data on patients. Using the summary, form an outline of educational needs. Compare your practice performance against acceptable professional standards. You will have, in effect, performed a medical audit on yourself.

Having determined educational needs by searching for deficiencies in practice profiles, the next step is to formulate educational objectives. This simply means that a statement of what you hope to do or know at the conclusion of the program is clearly defined.

For example, by evaluation of your practice, you determine that you need to know more about the management of hypertensive encephalopathy. Your goal is the reduction of mortality from hypertensive crisis. The objective, then, would be to increase your knowledge and skills in dealing with this entity—specifically, knowledge pertaining to newer antihypertensive drugs and their use.

There are a number of methods by which knowledge may be gained. Suppose that you decide, in keeping with the above example, that a lecture course would best suit your needs because you are attempting to gather new facts. Several sources of programs are available. The most comprehensive list is found in the August supplement of the Journal of the American Medical Association which details Category One accredited meetings held throughout the country and is broken down by medical specialties. Specialty journals also include course announcements. PENNSYLVANIA MEDICINE provides comprehensive course listings in the September and January issues. When you have found one or more possible conferences, write for information concerning the program. Not all conferences on hypertension will include hypertensive crisis.

Do not overlook your own hospital departmental programs. Many are of excellent quality and may be tailored to your needs. Medical staff meetings may also provide information since many are based on medical audits. The list of accredited Pennsylvania hospitals is increasing since greater emphasis is being placed on continuing medical education.

Finally, when the program is over, evaluate it. Have you reached your objectives? Your methods of treatment should have changed and as a result improved your patient care. Continuous review of your practice will reveal the benefits of careful selection of continuing education courses.

David A. Smith, M.D.
Medical Editor

HMO Act of 1973

(Continued from page 13)

more than most venturers can afford. Thus, governmental assistance during these early stages of an HMO's development has been essential.

The Act appropriates $165 million dollars over three fiscal years simply to grants and contracts for "feasibility surveys, planning, and initial development." There are, of course, certain limits on any single organization's support. No single grant or contract for a feasibility survey may exceed $50,000, nor may a grant, contract, or loan guarantee for planning exceed $125,000. Furthermore, the federal assistance may not exceed 90 percent of the total costs (unless the HMO is to serve a "medically underserved population"), so that some economic stake is required of the organizers.

It is likely that there will be far more requests for financial assistance than there is money available. Thus the HEW officials acknowledged the likelihood of "intense competition" for grants resulting in an inordinate emphasis on application preparation. The best prepared and most knowledgeable applications, showing sound planning and commitment, will obviously receive the best reception.

In view of this competition and stress on the application process, I believe a potential HMO will have to invest substantial time and money simply to reach the point of seeking federal assistance. Since the applicant could be a physician group, an insurance company, a hospital or medical school, a public community service group, a labor union, a foundation, or of any other basic form, the applications will vary rather dramatically. Physician groups must recognize their disadvantage in this competition unless they invest heavily in business help to plan the earliest "prefeasibility" study stages and then to prepare the all-important application.

Conclusion

This first article has attempted to demonstrate the *significance* of the new HMO Act before even describing HMOs and the Act's many requirements of form and activity. I hope it has been helpful in showing that HMOs will become a major influence on medical practice through their marketing activities and their financial assistance opportunities.

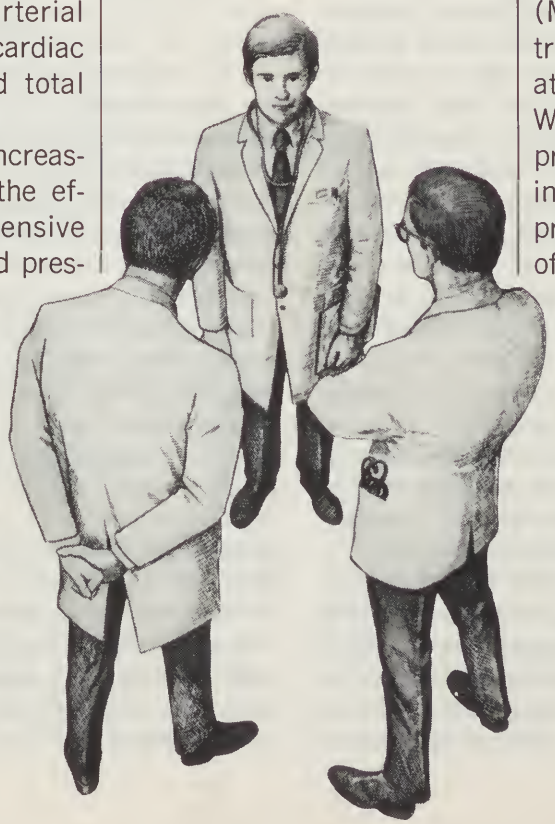
HMOs will create both threats and opportunities for the private practitioners. The threats, of course, emanate from the economic competition developing as an HMO grows in a specific area and as physicians relocate in response to these growth patterns. The opportunities may be just as exciting, for physicians might: (1) join together and form their own HMOs; (2) become the core "medical groups" of HMOs sponsored by other organizations; or (3) contract with HMOs to provide independent specialty services to the HMO members.

Next month's article will consider the Act's guidelines for organization and operation of an HMO and how physicians can deal with these three alternatives.

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

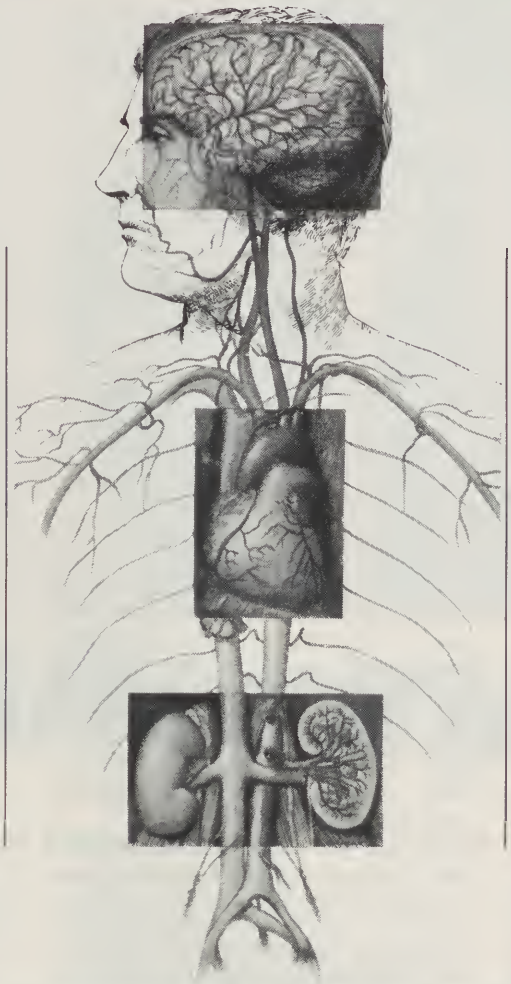
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Some patients on continuous methyldopa therapy may develop a positive direct Coombs test. For more details, see the brief summary of prescribing information.

Contraindicated in active hepatic disease and known sensitivity to the drug. Not recommended in pheochromocytoma or pregnancy. It should be used with caution in patients with a history of liver disease or dysfunction. Discontinue the drug if fever, abnormal liver function, jaundice, or acquired hemolytic anemia occurs.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®
(METHYLDOPA | MSD)

smoothly lowers blood pressure

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®
(METHYLDOPA | MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: Acquired hemolytic anemia has occurred rarely in association with therapy with methyldopa. Should clinical symptoms indicate the possibility of anemia, hemoglobin and/or hematocrit determinations should be performed. If anemia is present, appropriate laboratory studies should be done to determine if hemolysis is present. Evidence of hemolytic anemia is an indication for discontinuation of the drug. Discontinuation of methyldopa alone or the initiation of adrenocortical steroids usually results in a prompt remission of the anemia. Rarely, however, fatalities have occurred.

Some patients on continued therapy with methyldopa develop a positive direct Coombs test; incidence reported has averaged between 10% and 20%. It rarely occurs in first six months of therapy, and if not seen within twelve months, is unlikely to develop with continued administration. Positive Coombs test is dose-related; lowest incidence occurs in patients on 1 g methyldopa or less per day. Reversal of the positive Coombs test occurs within weeks to months after discontinuation of methyldopa. Prior knowledge of a positive Coombs reaction aids in evaluation of cross match for transfusions. Patients with positive Coombs tests at time of cross match may exhibit incompatible minor cross match. When this occurs, an indirect Coombs test should be performed. If negative, transfusion with blood otherwise compatible in the major cross match may be carried out. If positive, advisability of transfusion with blood compatible in major cross match should be determined by hematologist or expert in transfusion problems.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsy in several patients with liver dysfunction has shown microscopic focal necrosis compatible with drug hypersensitivity. Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen; reversible agranulocytosis has been reported. Methyldopa may interfere with measurement of creatinine by alkaline picrate method and of uric acid by phosphotungstate method. When used with other antihypertensive drugs, potentiation of antihypertensive action may occur.

Usage in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Perform periodic hepatic function tests and white cell and differential blood counts during first six to twelve weeks of therapy or in unexplained fever. Discontinue if fever, abnormalities in liver function tests, or jaundice appears. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Discontinue drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Anesthetics requirements may be reduced; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension may occur after dialysis because methyldopa is removed by this procedure.

Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Do not exceed recommended daily dose of 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure, including dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency, are seen occasionally. Angina pectoris may be aggravated. Symptoms of orthostatic and exercise hypotension may occur; if symptoms occur, reduce dosage. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distension, constipation, flatus, and diarrhea occur occasionally; these can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently; if edema progresses or signs of pulmonary congestion appear, discontinue drug. Rarely, urine exposed to air may darken due to breakdown of methyldopa or its metabolites. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, reversible thrombocytopenia, drug-related fever and abnormal liver function studies with jaundice and hepatocellular damage (see **Warnings** and **Precautions**), rise in BUN, and a single case of bilateral Bell's palsy.

Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

ADDENDUM

Let's make blood pressure "required reading" for all physicians.

With recent estimates that about 23 million Americans have high blood pressure—and that half of them are not even aware of it—detection of the problem in asymptomatic persons has become an issue of national importance.

Family physicians are being urged to take blood pressure readings as a matter of office routine, regardless of the presenting complaint or the reason for the visit. And because many people do not see a family physician for relatively long periods of time, some experts are suggesting that ophthalmologists, gynecologists, dermatologists, orthopedists, psychiatrists, dentists, school nurses, family planning counselors, and other health-care personnel make blood pressure reading a routine part of every examination or consultation.

Of course, a diagnosis of hypertension cannot be made on the basis of a single reading, but routine blood pressure readings can uncover potential trouble in a certain proportion of patients. And when trouble is suggested, further evaluation can be pursued more effectively.

Blood pressure—"required reading" for all physicians.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol C III SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL
McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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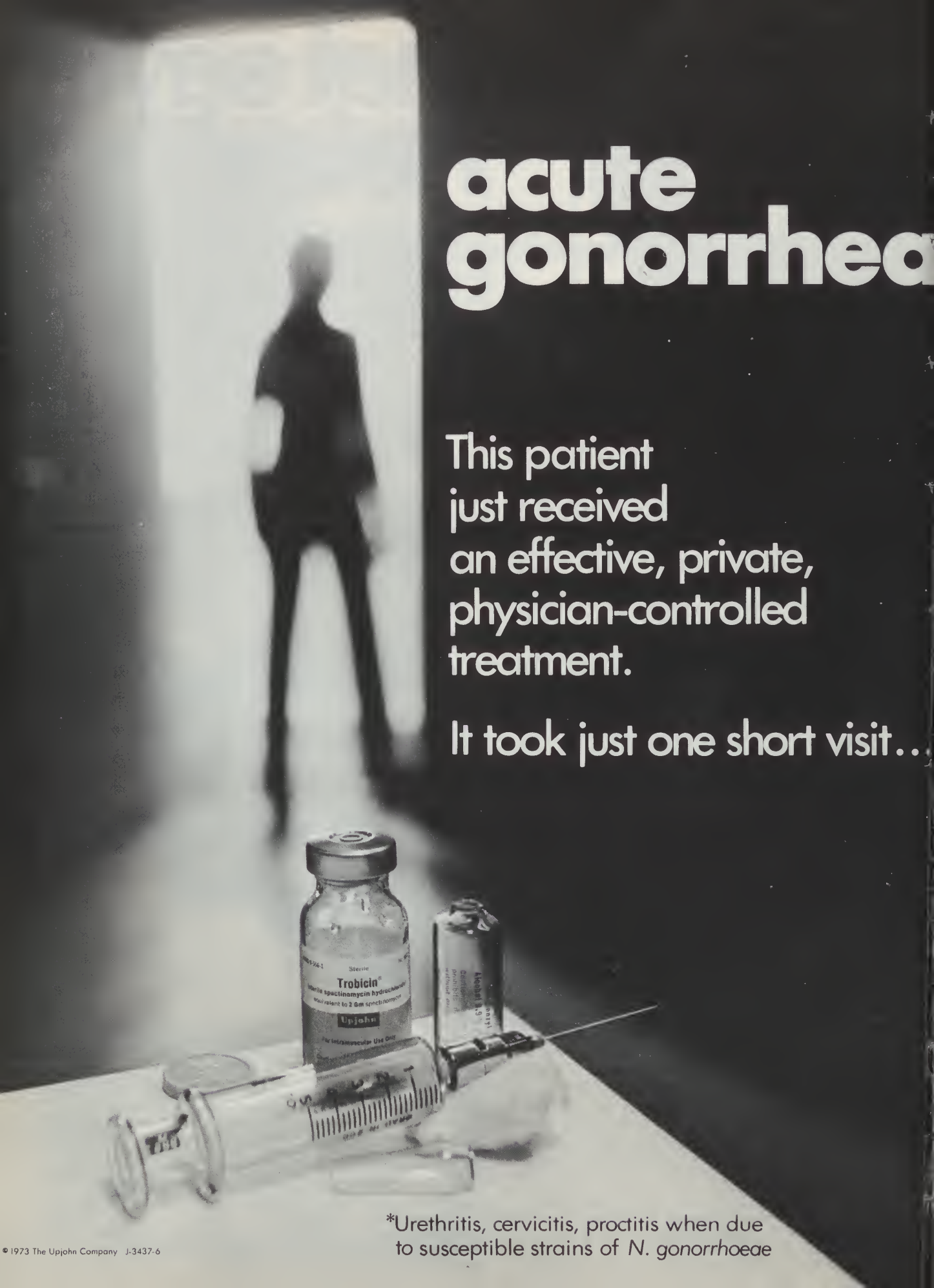

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—**Inject 5 ml intramuscularly** for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—**Inject 10 ml intramuscularly** for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
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† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

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Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

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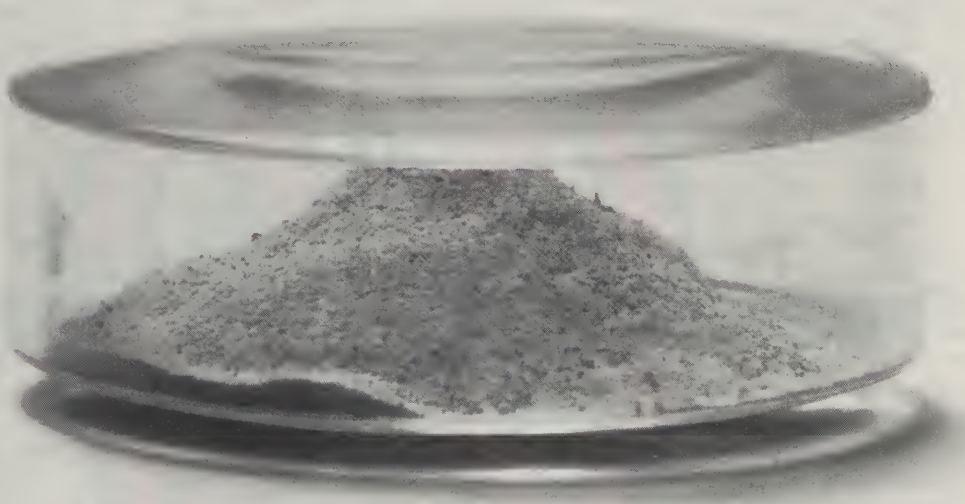

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(thyroglobulin)

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Another new benefit to members of Pennsylvania Medical Society

M.D.s in the news

Frank I. Marlowe, M.D., Wynnewood, assistant professor of otolaryngology at Medical College of Pennsylvania, has been elected vice president of the recently formed Philadelphia Society of Facial Plastic Surgeons. Dr. Marlowe is a fellow of the American College of Surgeons, the American Academy of Ophthalmology and Otolaryngology, and the American Academy of Facial and Plastic Reconstructive Surgery.

Warren W. Nichols, M.D., senior physician in the division of metabolism and genetics at Children's Hospital of Philadelphia, participated recently in a symposium on the potential genetic effects of environmental pollutants which was held in Moscow and Kiev, U.S.S.R.

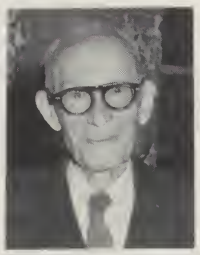
George L. Jackson, M.D., director of nuclear medicine at Harrisburg Hospital, has been elected to the first Board of Regents of the newly formed American College of Nuclear Physicians.

Robert W. Leipold, M.D., McClure, has become director of the department of community medicine at the Geisinger Medical Center in Danville. He is a past president of the Mifflin-Juniata Medical Society and is a diplomate of the American Board of Family Practice. He expects to establish a family practice residency program at Geisinger.

Geisinger Medical Center, Danville, has announced a number of new staff appointments. They are: **Carl L. Reams, M.D.,** associate in the department of otolaryngology; **Francis K. Moll, M.D.,** associate in orthopedic surgery; **Hugh R. Williams, M.D.,** associate in psychiatry; and **John T. Fazekas, M.D.,** associate in the department of radiology.

Four Luzerne County Medical Society members have earned the PMS Fifty-Year Award. They are: **Louis W. Jones, M.D.,** Harveys Lake; **Charles J. Kistler, M.D.,** Kingston; **Michael Murphy, M.D.,** West Pittston; and **Francis G. Tonrey, M.D.,** Mountaintop.

The current edition of *Who's Who in the World* contains the name of **Hartwig Kuhlenbeck, M.D.,** Ph.D. He is professor emeritus in anatomy at the Medical College of Pennsylvania. He is currently completing the final volumes of an extensive investigation in comparative neurobiology. In 1963, Dr. Kuhlenbeck was internationally recognized by being elected to the Max Planck Institute for Brain Research. The society has a membership of about 200 of the world's foremost scientists.



DR. KUHLENBECK

DR. HAASE

Gunter R. Haase, M.D., has been appointed director of the department of neurology of Pennsylvania Hospital and named a full professor at the University of Pennsylvania School of Medicine. He was formerly professor of neurology at Temple University School of Medicine and chairman of the department at Temple University Hospital. He is a diplomate of the American Board of Neurology and Psychiatry and a fellow of the American Academy of Neurology, the Association for Research of Nervous and Mental Diseases, the American Association for the Advancement of Science, and the Philadelphia College of Physicians.

James C. Giuffre, M.D., executive and medical director of St. Luke's Hospital and Children's Medical Center, Philadelphia, has been given a distinguished service award and presented with a check to be used for hospital improvements by the Italian American Press, Radio, and Television Association. Dr. Giuffre has established a waterfront clinic, an airport clinic, and a drug education program for policemen, all of which are administered by St. Luke's Hospital.

Richard L. Naeye, M.D., chairman of the department of pathology at the Milton S. Hershey Medical Center, Pennsylvania State University, has received a U.S. Public Health Service grant for research on the vascular factors in hemodynamic regulation. **Charles W. Lloyd, M.D.,** professor of obstetrics and gynecology at Hershey, has received a grant from Lilly Research Laboratories for research on blastokinin and prostaglandins in human endometrium.

Eugene G. Isidro, M.D., Lawrence, has been named chief pathologist and director of clinical laboratories at Jameson Memorial Hospital, New Castle. The new associate pathologist is **Bienvenido S. Ong, M.D.** Dr. Isidro is a diplomate of the American Board of Pathology and a fellow of the College of American Pathologists and the American Society of Clinical Pathologists.

The Chester County Medical Society has honored **Edith Johnson, M.D.,** West Chester, with presentation of a PMS Fifty-Year Award.

James H. Gault, M.D., has been appointed senior physician and chief of cardiovascular laboratories at the Lancaster General Hospital. He was previously professor of medicine and chief of the division of cardiology at the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey.

Elizabeth Blackwell, M.D., received a singular honor when the U.S. Postal Service issued a commemorative stamp in her honor as the first woman in the western hemisphere to earn a medical degree. Presentation of the honor was made at a meeting of the Montgomery County Medical Society recently.

Mayer A. Green, M.D., Pittsburgh, recently served as program director of the postgraduate course in pediatric allergy of the Association of Convalescent Homes and Hospitals for Asthmatic Children held at Miami Beach, Florida. He was named president elect of the association.

m.d.'s in the news

Harry Prystowsky, M.D., provost and dean at the Milton S. Hershey Medical Center of Pennsylvania State University, was one of four participants in a seminar of the National Academy of Sciences Institute of Medicine Overview Committee on Education and Health Professions in Washington, D.C., recently to debate the role of regulations as seen by health universities.

Cyril H. Wecht, M.D., Allegheny County coroner, has been elected chairman of the Allegheny County Drug and Alcohol Planning and Implementation Council. He is chairman of the drug abuse committee of the Allegheny County Medical Society, clinical associate professor of pathology at the University of Pittsburgh Schools of Medicine and Dental Medicine, research professor of law, and director of the institute of forensic sciences at Duquesne University School of Law.

Jaime M. Singzon, M.D., has been named medical director of the chronic respiratory disease clinic at Shamokin State General Hospital. The clinic has been established for black lung disease victims and victims of other industrially caused respiratory ailments. Dr. Singzon is a fellow of the American Thoracic Society and the American College of Chest Physicians.

Harold R. Schumacher, M.D., co-director of hematology at Harrisburg Hospital, has been certified by the American Board of Internal Medicine in the subspecialty of oncology. He is also certified in hematology.

The late **Louis A. Krimm, M.D.**, of Williamsport, has been named recipient of a Dr. John W. Lauler Memorial Award for contributions in the field of rehabilitative medicine. Presentation was made by the Lycoming County Medical Society to Mrs. Krimm, whose husband had been instrumental in establishing the Williamsport Hospital's physical therapy department.

Frank R. Bondi, M.D., chairman of the department of surgery at McKeesport Hospital, has been named "Man of the Year" by the Greater McKeesport Jaycees. Dr. Bondi is president of the Southwestern Pennsylvania chapter of the American College of Surgeons and a member of the American Board of Surgery.

Gerald J. Effinger, M.D., Penndel, has been awarded Philadelphia State Hospital's annual award for outstanding individual achievement in 1973. The citation was for introducing new tuberculosis treatment which has completely eliminated the disease at Byberry. His program is being adopted in other Pennsylvania state hospitals.

Steven Barrett, M.D., Allentown, member of the PMS Committee on Quackery, was a speaker at the annual meeting of the American Association for the Advancement of Science which was held in San Francisco recently. He spoke in opposition to the health and organic food fad, charging it is largely based on misinformation.

Anthony Kales, M.D., professor and chairman of psychiatry and director of the sleep research laboratory at the Milton S. Hershey Medical Center, Pennsylvania State University, reported in a paper in the February 4 JAMA that hypnotic drugs, although initially effective in relieving the symptoms of insomnia, lose their effect within a week or two and that their prolonged use often increases insomnia.

Robert J. Coffey, M.D., professor of surgery at Georgetown University School of Medicine, was the L. Kraeer Ferguson Visiting Professor of Surgery at the Medical College of Pennsylvania recently. He delivered a lecture on the surgical treatment of hyperparathyroidism, conducted teaching rounds with residents, and held seminars with medical students. Dr. Coffey is past president of the Southeastern Surgical Congress and a surgical consultant at the National Institutes of Health and the U.S. Naval Hospital in Bethesda, Md.

New Officers

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Charles K. Zug, M.D., vice president
John H. Hobart, M.D., Easton, treasurer
Joseph W. Fisher, Jr., M.D., Wilson, secretary

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Donald Pohl, M.D., Johnstown, president elect
Thomas J. Schaefer, M.D., Johnstown, vice president
Donald Mitchell, M.D., Johnstown, secretary
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Lycoming County Medical Society
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John P. Mraz, M.D., Erie, secretary
Robert J. Demuth, M.D., Erie, treasurer

Montgomery County Medical Society
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Ulysses E. Watson, M.D., Philadelphia, secretary
Joseph L. Hunsberger, M.D., Norristown, treasurer

Bucks County Medical Society
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Robert R. Koelsch, M.D. Sellersville, president elect
William A. Sugden, M.D., Buckingham, vice president
David P. Morrison, Jr., M.D., Doylestown, secretary
Carl M. Shetzley, M.D., Buckingham, treasurer

book review

Neonatology: Diseases of the Fetus and Infant. Edited by Richard E. Behrman. 698 pages, illustrated. St. Louis: C.V. Mosby Company, 1973.

This new book is a valuable reference for anyone who is involved in the care of the newborn. Written by thirty different authors, the book presents the most current material on the pathophysiology, diagnosis, and treatment of disorders which have their onset in utero or during the neonatal period. This book is comprehensive and detailed, covering every type of neonatal disorder. Divided into twenty-one chapters, each chapter is written by one or more authorities in each particular field, which gives the book greater depth than would have been possible with any single author edition. Each chapter is well illustrated and is concluded by an extensive bibliography.

A fifteen-page appendix of normal tables and drug dosages is included at the end of the book, followed by a detailed index.

The editor's expressed purpose of providing "a comprehensive and detailed description of the diseases that affect infants during the early weeks of life" is well accomplished by this textbook. Not only is the most up-to-date scientific and clinical data on each subject of this rapidly changing field of neonatology presented, but each section is also coupled with practical, useful treatment suggestions for the neonatal practitioner.

This book would be an extremely valuable addition to the library of any physician involved in the care of the neonate, both as a textbook and as a ready reference source.

Jay Marlin Nissley, M.D., Resident in Pediatrics
Polyclinic Hospital, Harrisburg

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ACUPUNCTURE

an ancient art in modern society

TERUO MATSUMOTO, M.D., Ph.D.
BRUCE A. LEVY, M.D.
Philadelphia

This paper was written at the request of the Pennsylvania Medical Society to clarify the current status of acupuncture to the professional community of Pennsylvania desiring to know more about this subject.

THE ANCIENT art of acupuncture (acus: needle, punctura: puncture) began long before the possibility of manufacture of such a metallic implement. Historically it began in the arid, rocky, barren Yellow River Valley of China which is not an area where the art of herbal or western medicinal therapy could flourish. When injury occurred and subsequent infections developed, these people, through a slow trial and error period, learned to drain the abscess and relieve the pain from it by the use of pressure applied to these painful areas. Pressure could be applied by the fingers or materials at hand, such as rocks and sticks. They also learned that when painful illnesses developed, they could relieve the pain and some of the disease symptoms by pressure applied to specific points on the body. Through the years these points have been refined, charted, and taught to aspiring practioners. These points are what we now denote as meridian or acupuncture points, and there are approximately 365 in use today.[5]

This ancient art, for the most part, would have remained unknown to the American public and professional community if President Nixon had not made his historic trip to China. After this event, the "in" word of the day was acupuncture, and the American public clamored for more information about it. The only problem was that everybody discussed the subject, but very few people knew very much about acupuncture. There were dramatic cures printed in the lay media, and occasional case reports could be found in the medical literature. However, no scientific, objective studies were reported in either. The American public wanted acupuncture, and in our society with its buyers' and sellers' market, acupuncture clinics began to appear around the country. No scientific or monetary control was placed on these establishments, nor was performing this form of therapy limited to medical physicians.

Dr. Matsumoto is professor of surgery and Dr. Levy is a fellow in the division of surgical research at Hahnemann Medical College and Hospital, Philadelphia. *The authors wish to thank Philip E. Ingaglio, M.D., member of the Pennsylvania State Board of Education and Licensure for proper guidance.*

At this point, the National Institutes of Health stepped into the picture to establish an ad hoc committee to scientifically study acupuncture under the leadership of John J. Bonica, M.D., the chairman of the department of anesthesiology at the University of Washington, Seattle, Wash. He has long been considered a leading expert in the management of chronic pain, and in his institution one of the first ethical pain clinics was established. The first meeting was held in February 1973 at the National Institutes of Health in Bethesda, Md. The senior author of this paper was one of the physicians who was invited to this meeting.[8] Dr. Matsumoto presented his beginning scientific animal and clinical research into this unknown subject of acupuncture. He was encouraged to pursue further objective clinical and animal research into the subject, and received permission from the Pennsylvania State Board of Medical Education and Licensure and the Institutional Animal and Human Research Committees of Hahnemann Medical College and Hospital to conduct ex-

perimental and clinical studies of acupuncture.

Ancient Theory

Classical Chinese medicine teaches that everything in the universe is made up of either positive (yang) or negative (yin) components, and that the body is made up of twelve specific organ systems, each one having its own specific meridian. Through these meridians flow the energy forces of life or "chi" in chinese ("ki" in Japanese). When disease or dysfunction occurs, it is evidenced as a disruption in the normal balance of energy flow. Six of these organs are considered to be solid (liver, heart, spleen, lungs, kidneys, and pericardium) and are believed to be controlled by the negative energy forces or yin. The other six organs are thought to be hollow (stomach, gallbladder, small intestine, large intestine, urinary bladder, and triple warmer) and are positively or yang controlled. If body balance should become disrupted and untreated by trying to establish normal energy patterns, the human's ability to react as a minicosmos in the universe would disappear, and death would ensue.[18]

This is only a brief discussion of ancient theory concerning acupuncture. However, we find it totally untenable with modern western medical knowledge and with the results which we have obtained in our experimental study of this art.

Experimental Animal Research

Two years ago we had no idea how to study acupuncture in the research laboratories. Through a slow trial and error procedure, we determined that a needle placed and manually stimulated in the second web space of the rabbit's paw would produce a great deal of analgesia while that in the third paw web space would produce only minimal analgesia. We then selectively manually stimulated the different anatomic structures in this area and found that direct stimulation of the superficial distal radial nerve reproduced the analgesic pattern obtained by cutaneous manual stimulation of the second web of the paw. However, no analgesia was obtained when stimulation was applied to the tendons, bones, or muscles in this area.[3]

The electroencephalographic pattern of all the animals was monitored to determine if there was any alteration in consciousness or if the animal experienced any pain. When the animal experienced any pain, a characteristic spike would appear on the electroencephalogram (EEG) (Figure 1). This spike could not be elicited with pressure, noise, or photic stimulation. To determine pain, the skin of the animal was touched with a test tube of hot water. If there was no response, the skin was tested with a 25 gauge needle. If still no response occurred, a kocher clamp was applied to the area. An area was considered to be analgesic only if the animal displayed no evidence of pain (crying, movement, or EEG spike) when these three painful stimuli were applied.

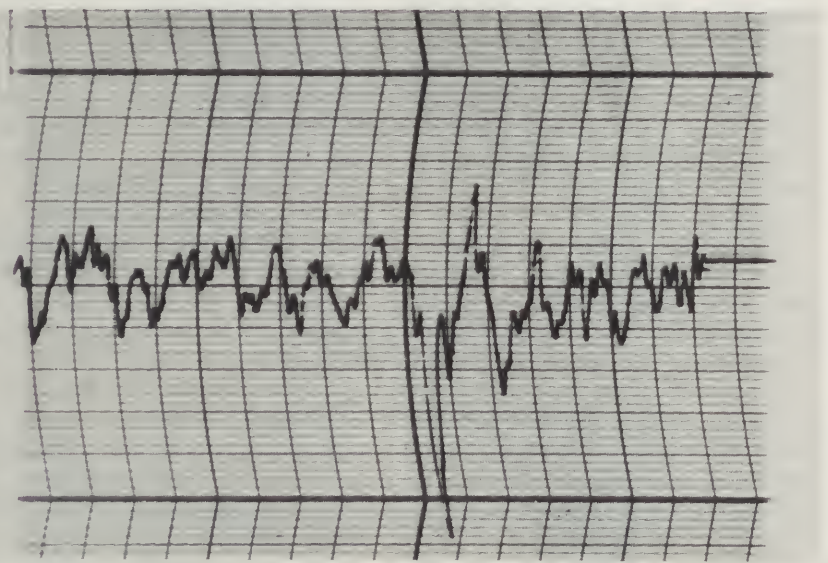

Figure 1. EEG spike with induction of pain on the animal.

We then acquired a signal generator because alterations of frequency and wave form could be accomplished with this apparatus. Again, through a trial and error procedure, we found the best location to produce analgesia was to have the negative lead on the vertex and the positive lead on the nerve directly. The generator could emit a square, delta, and sine wave. All wave forms produced some degree of analgesia, but the sine wave set at 10 kilohertz frequency and a current of 200 microamperes produced the best analgesic distribution.[9,13]

By surgically isolating nerves and then applying acupuncture to them with either manual stimulation or the newly acquired People's Republic of China acupuncture anesthesia apparatus 71-1 (Figure 2), we again found that acupuncture is directly transmitted by the nervous system. If the nerves were first precut or blocked with a local anesthetic, then no analgesia could be obtained upon subsequent acupuncture stimulation. Therefore, the performance of analgesia acupuncture requires an intact nervous system.[3]

Other observations showed that when adequate acupuncture analgesia was obtained, there was: (1) an increased incidence of bowel movements associated with visible peristaltic waves and high pitched peristaltic sounds[11,12]; (2) that in the areas of analgesia there appeared (grossly at least) to be no evidence of neuromuscular blockade; (3) in over 60 percent of the animals (sixty rabbits), a change from a quick beta to a slower beta rhythm occurred; and (4) in over 50 percent of these animals the electroencephalographic pattern converted to an alpha rhythm. No subject began with a normal alpha rhythm, nor was there any replacement of this alpha rhythm by low amplitude fast waves, nor superimposed upon this rhythm were there any sleep spindles which would indicate a decrease in the level of consciousness.[17] Finally, by

Figure 2. People's Republic of Acupuncture Anesthesia Apparatus 71-1.

Figure 3. Double Blind Study: Three needles placed, but only one being actually stimulated.

varying the placement of the needle along the course of the peripheral nerve, distally and proximally, a greater or lesser degree of analgesic area could be obtained.[13] Therefore, from our work certain assumptions can be made. Acupuncture is transmitted by the nervous system, requires an intact functioning nervous system to be successful, and is not a form of hypnosis. How, then, does it work?

Gate Theory

In 1965, Doctors Melzack and Wall[16] published a new theory on pain mechanisms which has come to be known as the Gate Theory of Pain. In essence it states that pain is carried to the substantia gelatinosa of the spinal column by small fibers, and it is in this area where modulation of afferent patterns sent to the central nervous system occurs. Since many of the larger fibers are inactive in the absence of stimulation, their stimulation by sheer size and number can block out a major amount of input by the smaller fibers. Therefore, a gate closes on the input of pain, and only the other sensations of the nervous system which are carried by larger fibers are allowed to be transmitted to the central nervous system.

We agree in large part with this theory as a possible neurophysiologic mechanism for the transmission of acupuncture. However, when proper acupuncture is performed, the patient experiences pain, "Te-chi" in Chinese, or "Tokuki" in Japanese. We have termed this sensation "needle shock." Therefore, it is our belief that acupuncture is transmitted to the spinal column by the small A delta and C pain fibers and not initially by the larger fibers. Once the suprathreshold level of pain is reached in the substantia gelatinosa, the neurons here close the so-called gate on the transmission of pain, and then only transmission of large fiber sensation to the central nervous system occurs.

Experimental Clinical Usage

We initially studied its effect on twenty-four patients with chronic pain from osteoarthritis of the cervical spine.[8,14] No patient had positive physical findings other than osteoarthritis of the cervical spine. All had been treated by their family physicians and by rheumatologists, neurosurgeons, or orthopedic surgeons for more than one year without appreciable improvement; and all had been referred by one of these physicians.

After being given a careful explanation of the procedure, patients were requested to sign a permit prior to acupuncture. No acupuncture was given on the initial visit, but rather efforts were made to screen the patients to be sure that they met study criteria, to evaluate mental stability, to give them a full understanding of the procedures, and to emphasize the importance of their assistance in obtaining accurate data.

A "single blind" study was conducted on one half (twelve) of these patients, and they were divided into three equal subgroups. A traditional acupuncture point was selected which was the most tender point along the neck-arm-hand musculoskeletal meridian. Two other points were selected which were not associated with a tender area, were not on traditional acupuncture meridian lines, and which elicited no "needle shock" upon stimulation of the acupuncture needle. On each point "sparrow pecking" and twirling were alternated every minute for ten minutes. The first subgroup of four patients received acupuncture on the specific point, while the other two subgroups received acupuncture on either one of the control points.

In the twelve other patients a "double blind" study was performed. Three needles were placed by a physician, but each electrical lead was attached by a third person in an order unknown to the physician (Figure 3). The twelve patients in this study were subdivided into three equal groups as follows:

Group 1: Electrical current was applied at the tender point for five minutes, and no current was applied to the two control points.

Group 2: Electrical current was applied to the first control point for five minutes, and no current was applied to the tender or the second control point.

Group 3: Electrical current was applied to the second control point

TABLE I

Group	Subgroup	Patient	Treatment Series									
			1	2	3	4	5	6	7	8	9	10
1	1	1	S	E	E	E	E	E	E	E		
		2	S	E	E	Discharged						
		3	S	S	S	E	E	E	E			
		4	S	E	T	Discharged						
	2	1	N	S	N	S	S	E	E	E		
		2	S	N	N	S	E	E	T	Discharged		
		3	N	N	N	N	E	E	E	T	Discharged	
		4	N	S	N	S	S	S	S	E	E	
	3	1	N	N	N	N	N	N	N	N	N	
		2	N	N	N	N	N					
		3	N	N	N	N	N					
		4	N	N	N	N	N					
2	1	1	S	E	E	T	Discharged					
		2	S	E	E	E	E	E	E	E	E	
		3	S	S	S	S	S	S	E	E		
		4	S	N	N	S	S	S	S	S	S	S
	2	1	S	S	N	S	E	E	E	Discharged		
		2	N	N	N	S	S	E	Discharged			
		3	N	N	N	N	N	S	S	S	E	Discharged
		4	N	N	N	N	S	E	E	S	S	S
	3	1	N	N	N	S	S	S	S	S		
		2	N	N	N	S	E	E	Discharged			
		3	N	S	N	N	N	S	S	S	S	S
		4	N	N	N	N	S	E	E	Discharged		

T = Total Improvement
E = Excellent Improvement
S = Satisfactory Improvement
N = No Improvement

for five minutes, and no current was applied to the tender or the first control point.

In all groups, three treatments were given seventy-two hours apart. All patients who had received acupuncture at the real points noted improvement of pain after treatment. The patients in the control groups experienced no improvement by the third treatment. The control group patients were then given acupuncture at the appropriate point, and the majority of these patients improved.

This study showed that acupuncture must be given at the specific point, and that it has a significant efficacy in the treatment of this disorder. The results are tabulated in Table 1.

After this initial study, the efficacy of acupuncture for the treatment of chronic pain due to cervical osteoarthritis (fifty-six patients) and lumbosacral osteoarthritis (fifty-two patients) was critically evaluated in the 108 patients.[15] The results as tabulated in Tables 2 and 3 show that ninety of the 108 patients (83 percent) in this study showed objective and subjective satisfactory improvement after acupuncture therapy.

There were four parameters used in the evaluation of these patients. The first three were of an objective nature, while the last parameter was of a subjective nature: (1) A 50 percent or greater increase in neck and shoulder or back and hip range of motion as compared to preacupuncture therapy; (2) A 50 percent or greater decrease in frequency and dosage of medications as compared to preacupuncture therapy; (3) The L-C neurometer (Figure 4) readings decreased to 50 milliamperes or lower as compared to 100 milliamperes or greater preacupuncture readings at the tender musculoskeletal arm-shoulder-neck or lumbosacral-sciatic meridian points; (4) Subjective opinion of the patient that his pain was much improved, his ability to perform daily activities was increased, and emotionally the patient felt better. The results were evaluated and tabulated in the following manner.

1. Total improvement: Full range of motion (off all medications), neurometer readings of zero at the affected points, and subjective improvement (T).

2. Excellent improvement: Positive results in all four of the parameters studied (E).

3. Satisfactory improvement: Positive results in three out of the four parameters studied (S).

4. No improvement: Positive results in two or less of the

TABLE II

Effect of Acupuncture on Cervical Osteoarthritis

Group	Number of Patients (%)
Total Improvement	14 (25%)
Excellent Improvement	21 (38%)
Satisfactory Improvement	12 (21%)
No Improvement	9 (16%)
Worse	0 (0%)
Total	56 (100%)

TABLE III

Effect of Acupuncture on Lumbosacral Osteoarthritis

Group	Number of Patients (%)
Total Improvement	10 (19%)
Excellent Improvement	19 (37%)
Satisfactory Improvement	14 (27%)
No Improvement	9 (17%)
Worse	0 (0%)
Total	52 (100%)

Figure 4. L-C Neurometer.

parameters studied (N).

5. Worse: Any negative result in any of the parameters studied (W).

From the results it can be seen that acupuncture has a statistically significant efficacy in the treatment of chronic pain resulting from osteoarthritis of the cervical or lumbosacral spines. An interesting finding is that no patient became worse from the therapy.

From the above studies, the efficacy of acupuncture was established, and it was shown not to be a result of a placebo effect. However, some form of psychological factor cannot be totally excluded. It is essential to have well-controlled studies with reasonable statistical analysis for any disease process in order to establish the efficacy of therapy (This clinical study was presented at the 59th Clinical Congress of the American College of Surgeons in Chicago, Illinois, in October 1973, and complete details of our studies will be published as part of a monograph entitled "Acupuncture for Physicians," by the Charles Thomas Publishing Company of Springfield, Ill).

Anesthetic Usage

Dr. Levy, the junior author, has completed fifteen months of clinical training in anesthesiology, and for the past year has been a fellow in surgical research studying the effects of acupuncture and doing basic science research into this field. All of Dr. Levy's training has occurred at Hahnemann Medical College and Hospital. However, next year he will attend the University of Washington Medical School in Seattle to complete his training in anesthesiology and to develop some expertise in the use of local anesthetics for the treatment of chronically painful disorders, under the supervision of John J. Bonica, M.D. Dr. Levy has administered close to 1,000 anesthetics, and this type of background is essential for the study of acupuncture in its intraoperative usage.

Even in China, acupuncture anesthesia is a young science, having begun approximately fifteen years ago. Although its application was once more popular, currently its usage is restricted to less than 20 percent of the intraoperative cases performed in the Republic of China.[10] Reports from the Orient tell of major surgical procedures being performed under acupuncture, and here in this country dental procedures[2,4] and childbirth[1] have been successfully performed using this method of anesthesia. However, one fact must be understood, and that is that the majority of these procedures could be adequately performed under local anesthesia by competent general surgeons. From our experience and from discussion of this subject with our colleagues in the field of anesthesiology, we have come to believe that a large percentage of the American public desire to have general anesthesia for surgical procedures instead of witnessing the procedure. If this were not the case, many more anesthetic procedures could be and would be performed under local anesthesia instead of general anesthesia. Since general anesthesia carries a mortality risk of from 1 in 5,000 to 10,000 cases and can cause other problems such as malignant hyperthermia, nausea, atelectasis, and drug reaction, we believe that acupuncture anesthesia may have some indications for use in modern surgery. This, however, will require education of the American public by competent anesthesiologists so that patients may understand which form of anesthesia may be best for them in a given procedure.

The advantages of acupunture are that the patient is conscious, can communicate, has minimum postoperative pain, has minimal side effects, and it is an easy method to learn and perform.[7,10]

We have read about a thoracotomy being performed under acupuncture anesthesia in China, during which time the patient spoke and drank water. Doubts come to our minds concerning the preoperative and postoperative care of the patient. Was the patient given a bilateral pneumothorax preoperatively and intensive chest physical therapy? If this was not done then how could the patient breath easily after the chest was opened? Atmospheric pressure would cause the lungs to acutely compress and the patient would require a great deal of positive pressure ventiliation to reexpand his lungs. How did the patient compensate for the large V/Q abnormality or shunt which would arise during this procedure? Much more scientific information is necessary before we allow lay reports to color and influence professional thinking. The primary factor which we must always keep in mind is the safety of the patient.

Indications for the use of acupuncture include the patient's desire for this form of anesthesia, his general state of health, and the type of operation to be performed. Therefore, minor surgical procedures such as excisions, biopsies, and dental extractions could be performed quite well using this method. There appears to be an even greater indication for use of acupuncture in childbirth because of the lack of risk of placental transfer and depression of the fetus by anesthetic agents. It could also prove to be a boon to those patients who have to undergo minor surgical procedures and who have shown adverse reactions to anesthetics in the past or where the anesthetic risk far outweighs the surgical risk—such as a lipoma of the back which is too large to be done under local anesthesia and would require general endotracheal anesthesia. Also included in this group could be ear, nose and throat, genitourinary, and gynecological surgical procedures.

Although we feel that acupuncture may be indicated as suitable anesthesia in childbirth, we still do not know what effects, if any, could occur to the mother or fetus by its use. Again, much more scientific information must be obtained before it can be used routinely on the pregnant female.

We have been studying acupuncture for over two years and have performed it on over 1,000 animals[9,13] and 500 patients to total approximately 5,000 applications of acupuncture. This was our preparation before we ever attempted to use it as an intraoperative anesthetic agent.

We have performed three sur-

gical procedures using acupuncture as the sole means of anesthesia. None of the patients were given any form of premedication, but a preoperative interview to discuss the procedure was held. These operations were performed on January 31, 1974; February 1, 1974; and February 14, 1974.

The first patient was a 42-year-old white male who had a five year history of a mass on the back. The patient was in good health, having no known medical problems, and his chest film, EKG, SMA-12, complete blood count, and coagulation profile were all within normal limits. The mass was a sebaceous cyst located in the subcutaneous plane over the T_4-T_6 spinous processes. The mass measured 5 cm in length, 5 cm in width, and was 3 cm in depth. The patient was given manual acupuncture at both "Hoku" in Chinese and "Gokoku" in Japanese (Figure 5), first dorsal web, acupuncture points for fifteen minutes. This was continued for another twenty minutes while the procedure was taking place. The patient experienced no pain except a sensation of pulling when the mass was being extracted. The patient had no pain in the incisional site for two hours after the procedure, and he required only thirty mg of oral codeine that night and once the next afternoon.

The second case was that of a 40-year-old white female who had undergone a right radical mastectomy three years prior to this operation for adenocarcinoma of the breast. That had been her first anesthetic experience, and she experienced an extremely difficult endotracheal intubation because of an unknown tracheal stenosis. All of her routine laboratory studies were within normal limits (as with the first patient), and acupuncture anesthesia was elected for the present procedure—a left supraclavicular lymph node biopsy. Again, manual stimulation was given to both Hoku points for fifteen minutes, and the procedure was performed within fifteen minutes while this manual technique was continued. The patient experienced no pain during the procedure except for the sensation of pulling. She could describe to Dr. Matsumoto what instrument he was using, but did not experience any pain from its application. She drank water immediately after the procedure and experienced no pain in the incisional area for forty-eight hours after the procedure was performed.

The third case was that of a 30-year-old black male who had an infected sebaceous cyst of the right earlobe. The patient was in good health and all of his routine laboratory studies were within normal limits. Again, manual stimulation was given to both Hoku points for fifteen minutes, and the excision and drainage was performed within ten minutes while the manual technique was continued. The patient experienced no pain during the procedure and none for the first six hours postoperatively. The patient then required only ten grains of aspirin orally to relieve his pain.

In all three cases the analgesic area which was obtained, using the classic anesthetic test of pinpricking, was from C_2-T_8 bilaterally. Although analgesia was obtained in these dermatomes, there was no corresponding loss of muscle power or loss of proprioceptive sensations. Therefore, it is our belief that acupuncture has a use in the field of anesthesiology, but it will be limited to a narrow scope of surgical patients.

Continued Experimental Research

Because of the incidental observation of increased peristalsis after acupuncture and a report of its use in decreasing postvagotomy gastrointestinal atony, we are now studying the effects of acupuncture on the autonomic nervous system directly in our laboratory.

Clinically, we have expanded our studies to include patients with intractable pain from carcinoma, migraine headaches, tic douloureux, postoperative pain, rheumatoid arthritis, and coronary artery disease, as well as its effects on neurosensory hearing loss, stroke of greater than six months in duration, and organically proven impotence.

Before using it on deaf patients, we obtain a complete ear, nose, and throat evaluation including tympanograms and audiogram. Although some of our patients state that they can hear much better after acupuncture therapy, repeat audiograms do not bear this out. One of two phenomena is occuring. Either the patient wants to hear better and believes that he does or the audiograms are not a sensitive enough technique to determine the increased threshold of hearing.

Out of twenty patients studied with proven, unresponsive migraine cephalgia, seventeen of these patients have been substantially

Figure 5. Hoku, Gokoku, or first dorsal web acupuncture point.

improved using similar objective and subjective parameters. These patients have now been followed for six months and are still doing quite well.

Conclusions and Precautions

Approval to do acupuncture in the State of Pennsylvania is dependent upon whether the program conforms with the present policy of the Pennsylvania State Board of Medical Education and Licensure, which has stated that acupuncture should be conducted on a research basis in the clinical setting of a medical school. At present, this is an appropriate attitude, because the safety of the patient must be the primary concern of the physician. Acupuncture should be performed only when the following conditions are met: (1) A proper medical evaluation is conducted to determine the diagnosis; (2) Acupuncture is a proper indication in the therapy of the disorder, for which the patient has not responded to conventional forms of modern medical therapy; (3) The proper technique of acupuncture must be applied by those who are skilled in this art.

The day may come when physicians will be able to train technicians and have them apply acupuncture under physician supervision, and in their offices. However, a great deal of training will be required before that day is reached, and currently, it is our belief that only medically licensed physicians should be performing this art. Such a training curriculum is presently being prepared in the division of surgical research at Hahnemann Medical College and Hospital. Finally, appropriate precautions must be taken so that this technique is not misused and so that adverse reactions to this form of therapy can be anticipated and properly treated if they do occur.

We stress these precautions because out of the more than five hundred patients we have treated with acupuncture, three patients who were referred by family physicians and specialists and who had been medically cleared had diseases which were best treated by means other than acupuncture. The first patient was an obese, 50-year-old white female who had been conservatively treated for shoulder pain for over one year. Upon examination the patient was found to have right upper quadrant tenderness. A cholecystectomy was performed following a positive oral cholecystogram, and the patient has had no recurrence of shoulder pain.

The second case was that of a 60-year-old white female who was diagnosed as having osteoarthritis of the left hand and who had been treated with oral analgesics without success for over two years. Examination revealed tenosynovitis of the left thumb. She received injections of local anesthetics and steroids, and the hand was immobilized for one week in a splint. Six months have elapsed since this treatment, and she has full use of the thumb without pain.

The third case is of a more serious nature. The patient, a forty-five-year-old white female, developed suture line pain ten years after a right radical mastectomy. She was hospitalized and evaluated for evidence of metastasis. However, all studies were negative. She received daily acupuncture treatment for five days and her pain resolved. She was seen two weeks later as an outpatient, and pain had returned to only a small erythematous area along the suture line. We were suspicious, biopsied the area, and the tissue diagnosis showed metastatic carcinoma. She received radiation and chemotherapy and is now doing fairly well. We bring this last case up for two reasons: First, to emphasize the need for continued observation of the patient even though the symptom has been relieved, and second, to remind physicians that patients may develop new disorders which are totally unrelated to the initial condition.

Modern medicine as developed in the western hemisphere and now practiced throughout the world appears to be highly effective in the cure of disease. However, there are still certain syndromes and diseases for which modern medicine is not effective in at least ameliorating the disruptive symptoms of these disorders.[6] Chronic pain is certainly one of them and frequently becomes a problem for the patient and his family. Patients suffering from chronic pain due to these disorders are considerable in number and may be helped by properly conducted acupuncture. It is essential, therefore, that these patients be thoroughly evaluated medically in order not to lose the golden period during which an underlying disorder such as carcinoma or infection, which is mimicking a benign chronic pain disorder, could possibly be treated effectively by standard modern medical therapy. □

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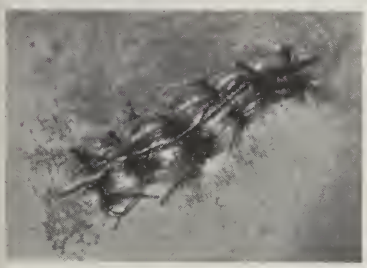

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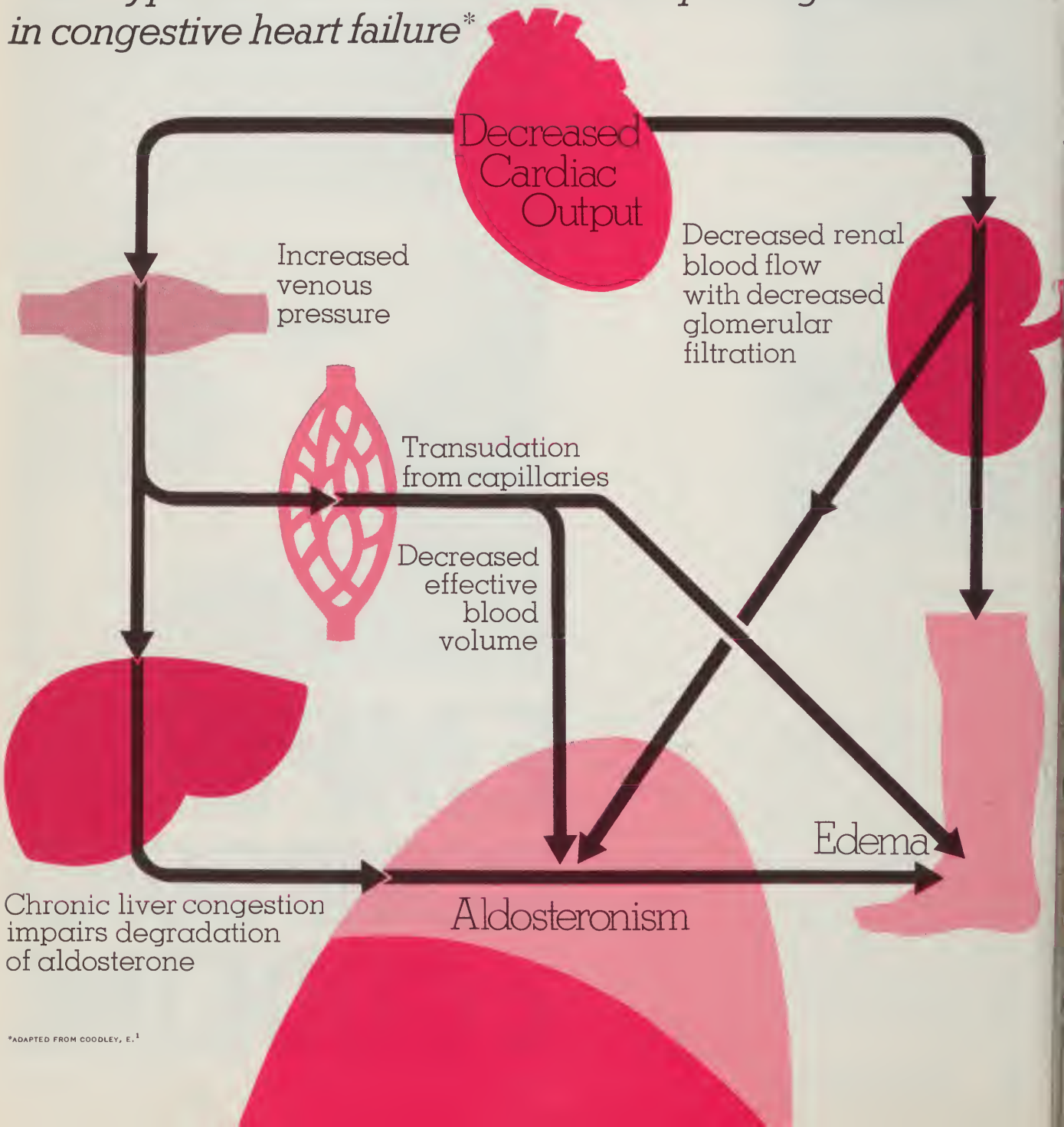

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Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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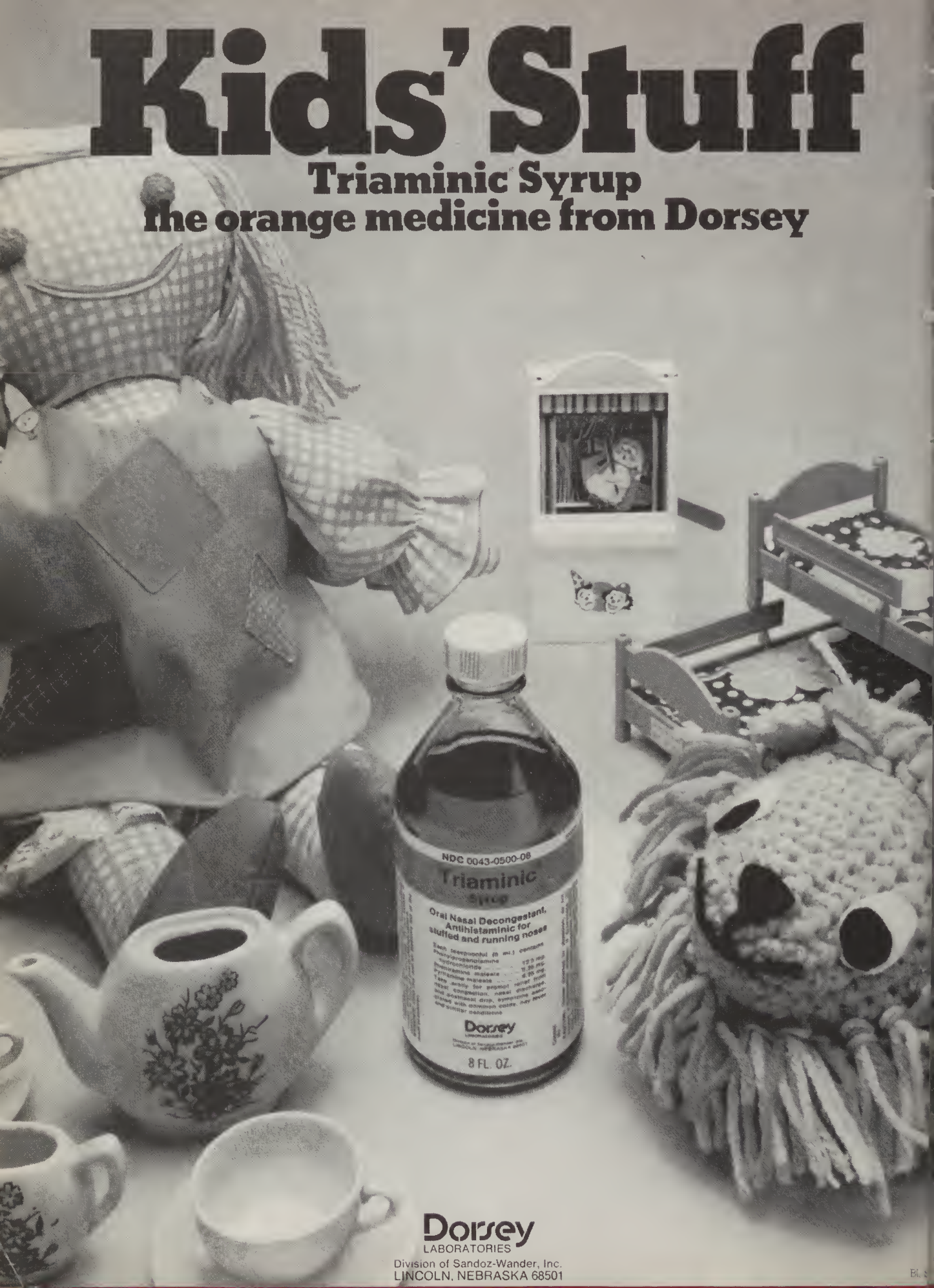

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

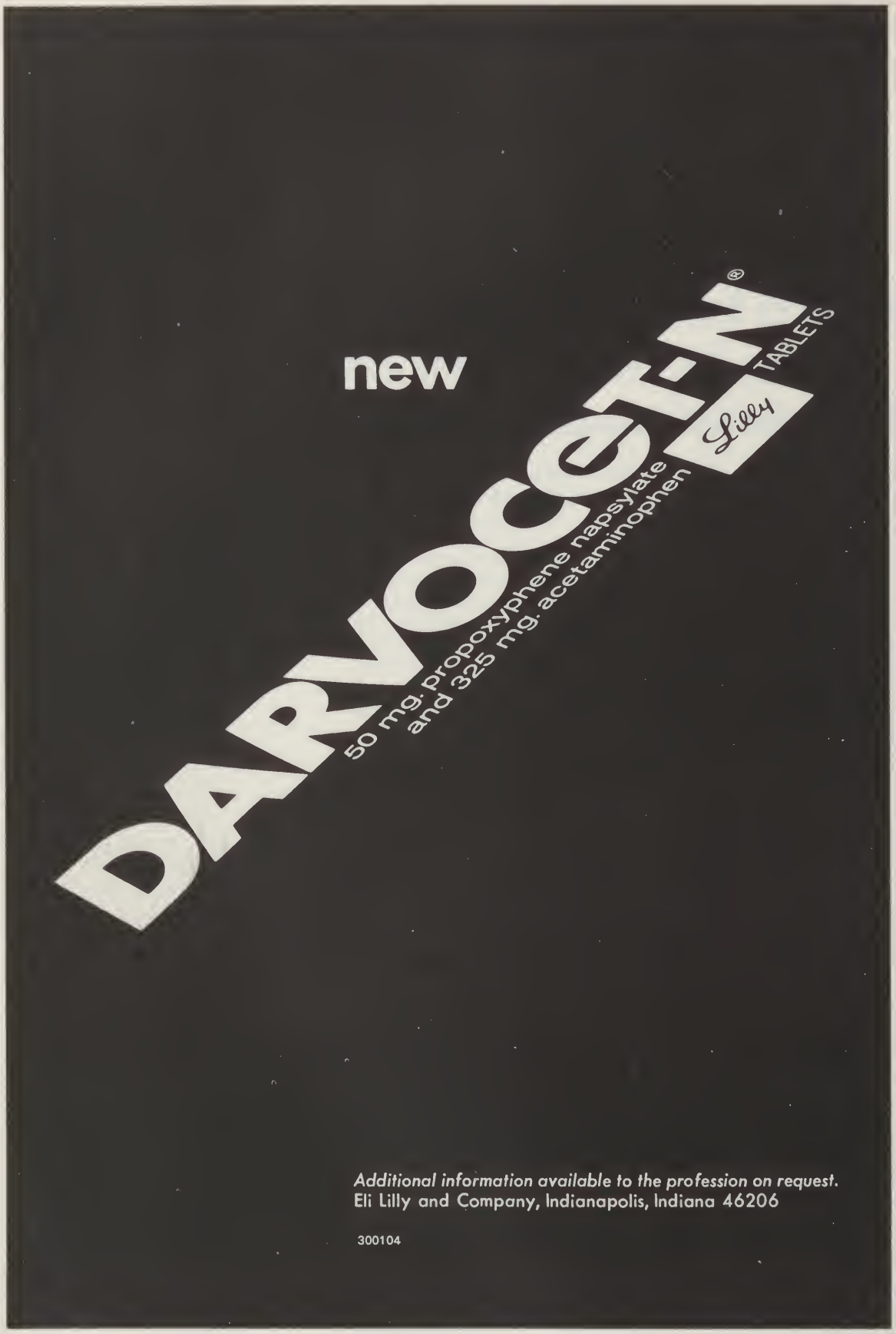
Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

P·M·A



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300104

Education programs require defining objectives

JOHN H. MOYER, M.D., D. Sc.
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MEDICINE as a profession is in a state of confusion largely because of lack of adequate definition of objectives. This confusion has not spared the education programs and faculties responsible for training physicians. Some of the most important aspects of medical practice have been poorly defined. This communication will attempt to suggest some possibilities of resolution.

Inappropriate Cost Accounting

A painful example of ill-defined objectives has been the modus operandi of federal support of medical education and research. There are those who would point the finger at organized medicine, the American Medical Association and its component parts, the Association of American Medical Colleges, and the various specialty societies, as being responsible for inadequate physician (especially family physician) manpower today. This accusation is quite inappropriate since the federal government and its support mechanisms are primarily responsible. It was the government which determined the policies and mechanism for financial support of medical research and education, and this in turn was primarily responsible for physician manpower distribution and the type and number of physicians being trained who are available today. It appears to the author that the federal government and especially Congress, through its funding mechanism of the last twenty years, failed to make a forthright determination of its objectives in broad perspective. The support has frequently been allocated on the basis of brush fire techniques and political expediency which unfortunately continues to be a modus operandi of many interested parties. Funding was and continues to be too frequently based on popularity of the moment or special interests of lobbyists which were not necessarily appropriately weighted in the context of an overall evaluation of medical need and the potential for bringing worthwhile programs to fruition.

Confusing the issue even more has been the inappropriate cost accounting procedures that were used in the medical schools and encouraged by the National Institutes of Health. The medical schools have become increasingly dependent upon the federal government because of its research programs support. Much of the funding obtained in the name of research was applied to general education and support of the medical schools' teaching faculty. As a result, most medical schools as of four years ago could not distinguish support funds which were appropriately being applied in support of research from funding being used for general education, which resulted in inappropriate support by the NIH through research grants. The sudden requirement of specific cost accounting by the government, probably more than any single item, has been responsible for the administrative chaos and the fiscal crisis that has suddenly gripped our medical schools. If this were not so, a reduction of research funds should not affect the educational process for the medical student. Because funding has been misapplied and the cost accounting system has been inaccurate, most medical schools are in a catastrophic situation as of this moment since research support has been curtailed or at least has not been increased to keep pace with the operational costs of the medical schools. This situation exists because we did not adequately define the objectives of the research being done in medical schools and of medical education in general in order to gain a precise evaluation of cost. *If we do not know what the package is, we can hardly determine the cost of purchase.*

With this increasing dependence on the government for support, even the private medical schools have gradually moved into the area of public domain and the consumer, i.e., the public, is not going to continue to pay for an item when he does not know exactly what the item is and what he is paying for. Fortunately, some of these problems are now on the way to solution through capitation grants for student education from both the state and federal governments which, in turn, are separated from grants for research support and which will be audited as such. The crisis that now exists in medical education is largely due to the fact that the federal government has reorganized its own cost accounting system, which has required that the medical schools follow suit.

These same problems permeate not only medical education, but our entire system of health care as well. The whole cost accounting system for support of the delivery of ambulatory health services is poorly defined and is currently oriented to the hospital rather than to the ambulatory patient health facility. For example, in most hospital insurance programs, including Blue Cross and medicare, it has not been possible to have diagnostic services paid for when the patient was not in the hospital (except in a few categories such as certain emergency x-ray studies). This has lead to unnecessary admissions and unnecessary exhorbitant expenditures. This is a catastrophic mistake which may well be corrected as more proficient ambulatory specialists are developed and trained.

Dr. Moyer is professor of medicine at Hahnemann Medical College. He is a member of the Pennsylvania Medical Society's Council on Education and Science. This paper was adapted from a Citation Address which the author presented before the All Pennsylvania College Alumni Association of Washington, D.C.

Categories of Physicians

Although fiscal problems are most obvious at this time, a determination of definition and objectives is just as lacking in the curriculum and organization of the academic and professional programs of the medical schools. For example, what is the definition of a family physician as contrasted to a general internist, or precisely what shall be the role of a family physician in the health care system? Certainly, the respective roles of these professionals must be determined if we are to be training family physicians as specialists in their fields. Furthermore, their relationship with the medical-surgical systems specialists and the general internist, pediatrician, and surgeon must be determined.

Today the purpose for which the physician is being trained has extended greatly and is quite variable. For example, the development of specialties oriented to sophisticated laboratory support has increased the complexities of medical education. In fact, the spectrum of activity for which the physician is being trained is probably as wide as in the liberal arts and the physical sciences. In the physical sciences no one would think of training a physicist by giving him the same course that is given to the chemist or the biologist, although there may be quite a bit of overlap in the basic or core curriculum.

The range of activity open to the physician as he is now deployed in the medical sciences encompasses: (1) the general practice of medicine and delivery of ambulatory health services, i.e., the family physician; (2) general internal medicine as the coordinator of institutional medical services with ambulatory services being a secondary responsibility; (3) medical systems specialty work-oriented around laboratory procedures in the interpretation of diseases by the body system involved; (4) surgery and its specialties; (5) administrative medicine such as in the Regional Medical Programs or government medicine; (6) research medicine requiring profound knowledge of laboratory technology, biostatistics, etc.; (7) environmental control and related work; (8) industrial medicine; and (9) additional categories.

Probably the category of physicians that is most urgently needed today is the specialist in ambulatory services, and this is where we must place the emphasis in medical school. That is, on the training of physicians who can and will become most proficient in treating patients who are ambulatory in the community setting. I define this prototype as a family physician. Because of background and conditions of training, many physicians are reluctant to accept this role today, or at least be so labeled, even though this is in fact their modus operandi. However, armed with an accurate definition and image, there is no doubt in my mind that the family physician trained in the future will become just as highly specialized in ambulatory services operating in his community as the specialty physicians oriented to hospitals are now. As in the case of emergency room specialists, this will require a complete new emphasis in the curriculum for training these physicians.

The Family Physician

The family physician, whether a member of a group or in solo practice, must be a specialist in ambulatory care in the community setting. If in solo or small group practice, he must assume directorship of the health care unit (Fig. 1). Specialists in general ambulatory medicine (family physicians) can be divided for the most part into two sub-categories: (a) the solo family physician or group of physicians in rural areas, and (b) the urban specialists primarily giving ambulatory care. The latter type of practice is likely to be one of three types: (1) a small clinic-type operation, including a small group of physicians with a large retinue of supporting personnel such as clinical psychologists, nurses, technicians, etc. (Fig. 1); (2) emergency room care; or (3) group practice of specialists for ambulatory care. Hospital practice will include a category of emergency room specialists who are also oriented to ambulatory services but who handle a general mixture of emergency problems on an emergency room basis as well as major emergencies since the emergency room is the entryway to the hospital for patients with acute medical problems. These family physicians, regardless of location, should have access to the hospital and should have admission privileges, but their primary expertise must be caring for ambulatory patients.

The organizational structure for managing ambulatory patients is through the clinic-type organization. A group of medical specialists and allied health personnel ban together for comprehensive ambulatory medical care. The total care of the patient and his family is dependent on the organizational cohesiveness and effectiveness of the group practice for success (Fig. 2).

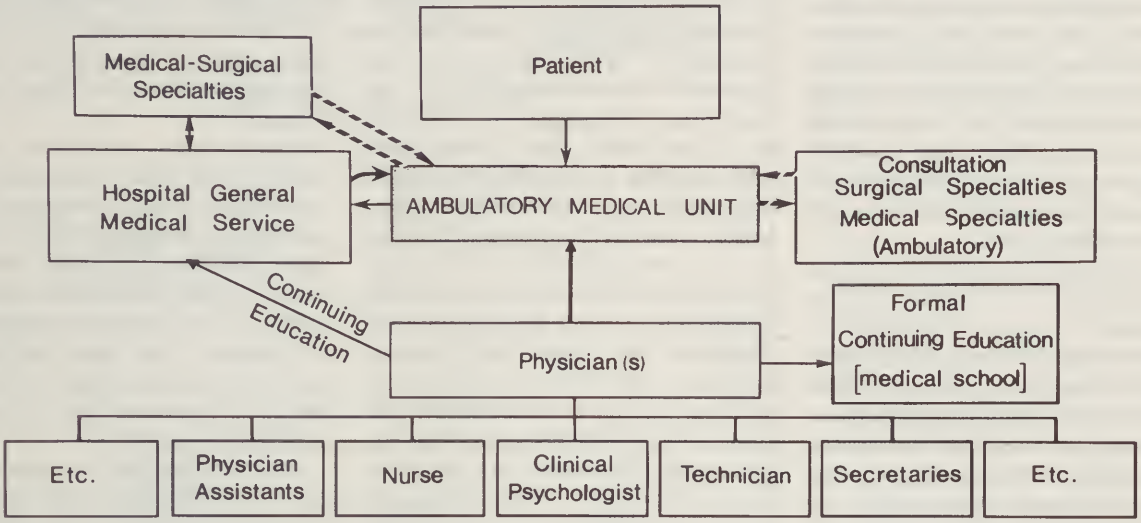
Departments of general internal medicine and pediatrics in the hospital should serve as coordinators of medical services throughout the hospital; that is, they must be able to accept uncategorical patients and also to coordinate the work of specialists in hospital medicine. This joint service then becomes responsible for interrelating the family medicine ambulatory service with the systems specialties, e.g. neurology-neurosurgery, cardiac surgery, nephrology-urology, etc. In this endeavor they will be working with the surgical specialists, many of whom will never have had training in the broad base of medicine according to our current training program. With these basic definitions as a guide, the organizational structure of the specialty of family practice and its relationship with the medical-surgical specialties can be developed. The degree to which the family physician can depend on specialists for support in the care of his patients and the degree to which he must be entirely self-sufficient will depend on the community being serviced and the resources available.

All of this clearly presents the need for redefinition of the primary physician as a family physician or as a member of a comprehensive group practice of specialists who care for the whole range of patients—primarily on an ambulatory basis. Obviously these physicians,

Figure 1

Continuing Education As It Relates To

AMBULATORY MEDICAL CARE AND HOSPITAL REFERRAL

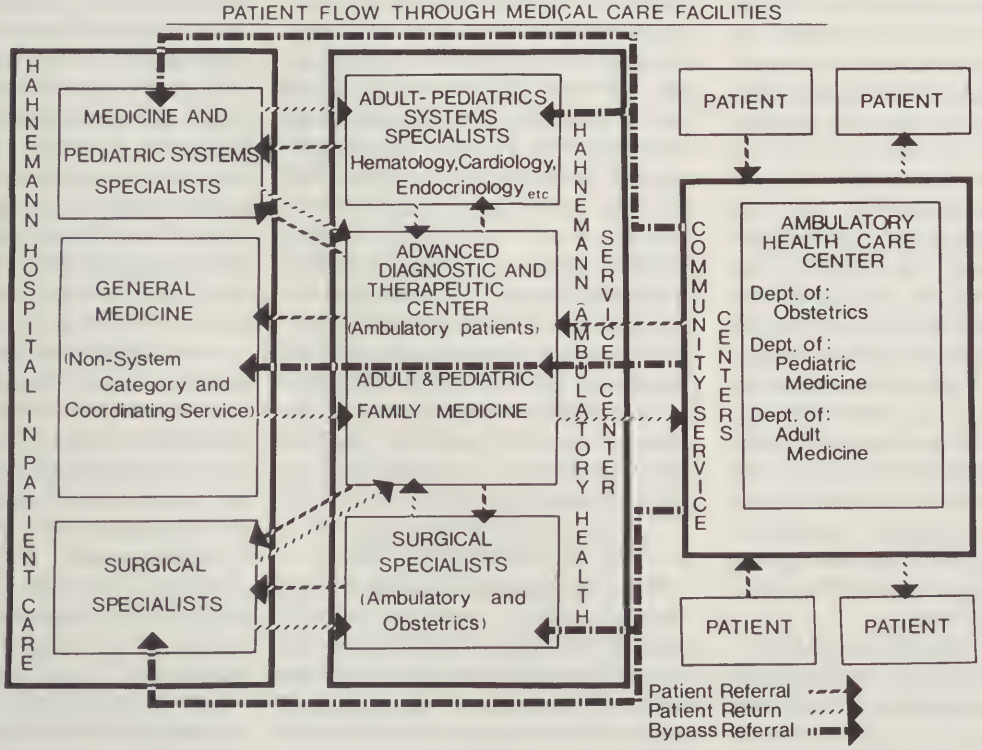


----→ indicates DIRECT PATIENT REFERRAL

——→ indicates PRIMARY PARTICIPATION IN PATIENT CARE OR PROFESSIONAL EDUCATION

Figure 2

PATIENT FLOW THROUGH MEDICAL CARE FACILITIES



to be effective, require not only scientific information, but also a knowledge of government facilities, availability or government support for medical care, and the availability of specialties, social services, etc. The great need for a general practitioner or family physician who has not categorized his practice has been emphasized in the stress placed on the health care delivery system and the shortage of physicians. Here again, we need to define our objectives.

Premedical School Curriculum

Because of the shortage of physicians and the mounting cost of medical education which is now rightfully being identified, there has been great pressure by the government and its accountants and also by the consumer (the public), *to reduce the time period allotted for the educational experience*. This approach has pitfalls and shortcomings. Efficiency in education should be increased, but neither quality nor quantity sacrificed for expediency. Is it our objective to develop a kind of scientific robot, who, from the day he enters college, concentrates on the science of medicine and disregards the humanities and socioeconomic factors that will affect his life and his environment when 80 percent of medical problems seen by a physician in general practice are primarily related to social and domestic stresses placed upon the patient? If we are—then let's be frank in acknowledging our objectives along with its deficits. We should not infer that drastic cuts in educational time will end up with the same quality of educational experience! Or should emphasis be on the development of a well-rounded, socially adjusted, and complete man as your physician! My choice would be the latter, especially since the so-called primary physician must direct much of his effort to counseling and advising the patient on his domestic and social problems.

Premedical education has not been as bad as many would have us think. The college premedical school curriculum should have a broad base in order to prepare the student for leadership and contribution to society, whereas the scientific education should be directly related to practical application of knowledge and training useful to the physician of the future. In summary, I would emphasize that our college curriculum should be designed to provide a broad base for the physician as an individual in his social and economic environment, but at the same time it should be more precise in directing his scientific development so that this is completely relevant to his scientific need as a future physician. I am suggesting the need for better definition of objectives, while at the same time stressing the need for greater precision and more scientific programming of our educational efforts. *I believe it an error to be so driven by the current economics of the situation as to accept or even approve of serious curtailment of college education, which will subsequently lead to production of an inferior product.*

The time has arrived for the Council on Education of the American Medical Association, the American Academy of Family Physicians, and the Association of American Medical Colleges to come to grips with the problem. A basic core of the scientific or basic science curriculum should be developed and recommended to the schools involved with premedical education. This should then be developed so as to interrelate with the applied sciences as given in the medical schools. For example, basic physiology and cell biology could be given in the premedical curriculum, but a general departure point should be established for the medical school in advanced cell biology and metabolism and in applied clinical physiology. The students then get off on at least a general common footing rather than in the complete lack of system that exists today.

Medical School Curriculum

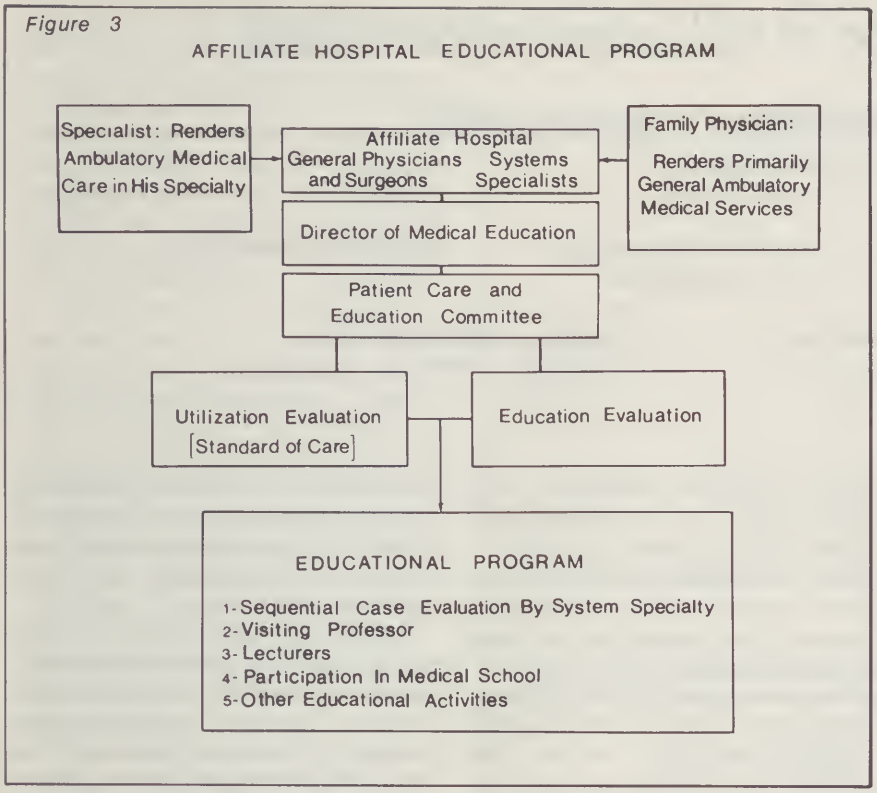
The same problem exists in the medical school curriculum that exists in the premedical school, i.e., *lack of definition of objectives*. The medical school's educational process also presents many of the problems that now complicate the teaching of the physical sciences, such as the accumulation of scientific information far exceeding the student's ability to encompass the entire breadth of knowledge available. This may lead to frustration and dilution, plus arbitrary curtailment of subject matter by the curriculum artists rather than selection with emphasis on a lifetime learning process.

In previous years the medical school curriculum has been fairly well standardized since the days of the Flexner Report, with all students taking the same courses. The spectrum of what physicians were expected to do was less variable than at present. We had the general physician and then the surgeon who was a "generalist who in addition wielded the knife."

The job description from physician to physician may be quite varied. It becomes obvious that what is good training for one of these careers may not be applicable to the others. Therefore, in order to adapt to this broad variety, many schools have established a series of electives which too often are not integrated and coordinated towards a specific goal or objective because the integration which the professors are unwilling or unable to undertake is left to the inexperienced student. Unfortunately, the student has little knowledge of what would be most useful to him for his future endeavor. Excessive elective time does not seem to be the best approach. It would seem more appropriate to have a basic core curriculum with selectives (rather than electives) to complete the major, i.e., the various types of future endeavor which would be adequate to meet further needs, just as there is a basic requirement for the speciality of chemistry in the liberal arts college, although additional course electives are acceptable in order to meet the total qualifications required of a chemistry major.

At some medical schools a track program has been established in which it is acknowledged that breadth of scientific information must be sacrificed for more in-depth knowledge of technology in a restricted area, with emphasis on the scientific approach to a problem.

Figure 3



The emphasis under these circumstances must be on the scientific method rather than on a total body of information available. Thus, after proceeding through the core curriculum, the student selects the line of endeavor that he will follow, in either the surgical or the medical specialties (including psychiatry and the laboratory specialties). When the student goes into the medical specialties, the curriculum is established so that he accumulates the basic information of internal medicine, and in addition, subspecialty experiences are offered. The student can select many of these, but a basic requirement is maintained.

This whole approach has emphasized the difference between the medical and surgical specialties. For the most part, the more developed the surgical specialty is, the more technical it becomes and the more dependent on gadgetry, equipment, and machines, such as cardiovascular surgery using heart bypass, heart assist, and pacemaker. On the other hand, the systems subspecialties in medicine require a major background of laboratory backup. This is quite different from seeing uncategorized patients in a general office practice.

Continuing Education Objectives

The need for definition of the objectives to be achieved in the continuing education program is just as important as in the medical school curriculum. Training in the surgical specialties and laboratory oriented subspecialties in medicine would necessarily be quite different from the continuing education of the primary general physician and the general internist.

Most of the educational effort in the highly scientific specialty services is being conducted by the physician's specialty society. Primarily, the surgeon keeps in touch with his surgical colleagues in order to remain abreast of progress in his field and scientifically advanced, as does the subspecialty hematologist, cardiologist, etc.

In the development of a continuing education program with a full format, the following three points must be included: (1) The program must be accessible to the physician; (2) The training and information dispensed must be relevant to the physician's practice; and (3) The program must be attractive and interesting. The medical college continuing education program can be divided into two large categories: (a) the medical school-based continuing education activities such as symposia, seminars, tutorial programs, and the university hospital training programs; (b) the affiliate institution for continuing education—it is this combine of integrated hospital educational programs that probably has the greatest potential for future achievement.

Each community hospital can become a secondary center for continuing education in its local community (Fig. 3). In turn, a representative from this center is incorporated into the planning process of the medical college and university hospital affiliation "family." The program must, then, of necessity be: (1) as relevant as the governing board (council) members make it; (2) as attractive and as effective as the board members make it.

However, the main problem still exists as to how to teach the physician who is not in a hospital and who does not wish to participate in continuing education. I suppose there are a number of approaches to such a problem which become evident. Two of these are: (a) long-term involvement by the selection of appropriate individuals by the premedical college as well as the medical college school selection and indoctrination programs; (b) a disciplinary club—that is, relicensure. Hopefully this can be avoided. Relicensure would require that the physician be certified as having participated in a continuing education program as well as re-examined—both of which procedures are rather complex to supervise. A beginning has been made by the Pennsylvania Medical Society towards a continuing education requirement for membership in the Society.

Medical care has long since passed the simple operation of the solo practitioner caring for patients alone in a simple private office. Complexities bring with it the necessity of organization, and organization requires the determination of goals and objectives which in turn requires precise definitions of terms. □

Comparison of two experiences using physician's assistants

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Carlisle

UNLESS there is a shift in the current emphasis in specialty training, educating more physicians may not increase the availability of primary health care. One alternative is the training of allied health professionals who can perform tasks ordinarily handled by the physician, but for which his long years of training are not required. These primary care practitioners would, under the preceptorship of a physician, increase his effectiveness by performing the physical examination and recording the history on all patients. This would screen and provide care for patients with routine health problems. The physician's skills would then be applied to those who need them.

This study, conducted in two different types of practices, measures the impact of a physician's assistant (PA) on the delivery of primary health care. Impact for the purpose of this study is defined as reducing physician encounter time per patient and increasing the availability of care to his patients.

Two settings were used in the study. One setting was a university medical center group practice comprising four physicians board-certified in internal medicine. The physicians are members of the faculty of the medical school and do not practice full time. Each physician has office hours three sessions per week. The other setting was a group practice in Carlisle, Pa. These physicians practice family medicine.

The physician's assistants who worked in these practices were in their second year of the Hahnemann Physician's Assistant Training Program. This preceptorship period allows students to function in the usual practice setting, but under direct supervision. In this learning situation, the preceptors use case problems to instruct the students.

The two students had different backgrounds before entering Hahnemann's program. The one in the medical center group practice had entered the program directly from high school and had not had previous medical experience. The second student, formerly a medical corpsman, came to the program with some clinical experience.

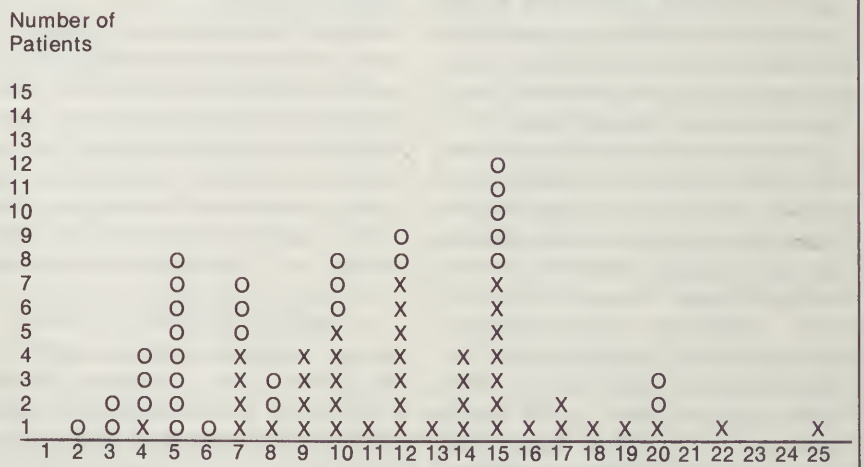
A form was filled out by the clinical staff for each patient encounter in both practices in late February and March 1973. Although the number of records approached 300, the sample was inadequate to provide comparison among the original subgroupings specified, e.g., age, sex, disease.

These are the hypotheses that were tested: (1) The physician's assistant reduces the mean physician time for patients whom they see jointly. (2) The age of patients is not a factor affecting physician's assistant utilization. (3) The physician's assistant will have an impact on the physician time spent on new patients, patients with routine acute diseases, and patients with chronic problems under control.

A large matrix was constructed to represent the subgroupings to test for significance by age, sex, and disease and for the individual

Figure 1

Frequency Distribution—M.D. Time per Encounter*



* Physician Time per Encounter in Minutes
Key: X represents an encounter without a P.A.
O represents an encounter with the P.A.

physician's potential utilization of the physician's assistant. The sample did not provide entries in each cell and provided only small sample sizes in others. Therefore, it was possible only to compare subgroupings for which there were encounters involving the physician's assistant and those involving the physician alone.

To test the first hypothesis, encounters involving all physicians in the sample of the medical center practice were aggregated. Figure 1 is a frequency distribution of physician time per encounter alone and time utilizing the physician's assistant. The median time for the combined samples was ten minutes. The chi-square test for small samples indicates that a statistically significant reduction in physician encounter time occurs with the use of physician's assistants (Table I).

The small-town practice data could not be treated in the same way. After six months, the physician's assistant handled his own patients and reduced the effective physician time to zero. Since the appointment secretary scheduled the PA for half as many as the physician, the potential access to medical care was increased by 50 percent.

The second hypothesis was that there was a difference in the impact of the physician's assistant according to the age grouping of patients and/or sex and/or problem treated. The sample of the patient contact records failed to provide entries in all cells of the matrix. Table II presents the impact of the physician's assistant on the row-column intersections for which there were data. Since the samples were too small for a statistical test of significance, the mean values are given and inferences are drawn by "observation." (These data are from the medical center practice. No comparison could be made for the small-town group practice since the physician's assistant operated independently.)

A frequency distribution of the patients seen by the physician's assistant, as compared with that of the physician in the small-town prac-

TABLE I

Medical Center Group Practice

Chi-Square Test on Physician's Encounter Times Patients with and without Physician's Assistant*

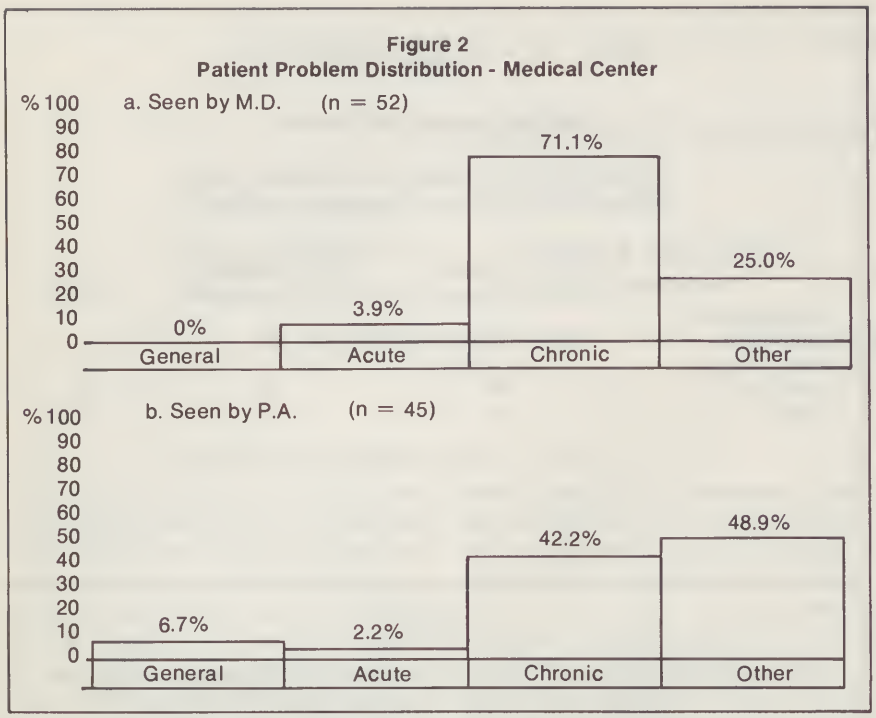
	No. of Patients ≤10 min. Encounters	No. of Patients >10 min. Encounters	Total
Patients seen without P.A.	15	28	43
Patients seen with P.A.	23	9	32
Total	38	37	75

* $X^2 = 8.62$; $p < .01$; Median time, 10 minutes.

TABLE II

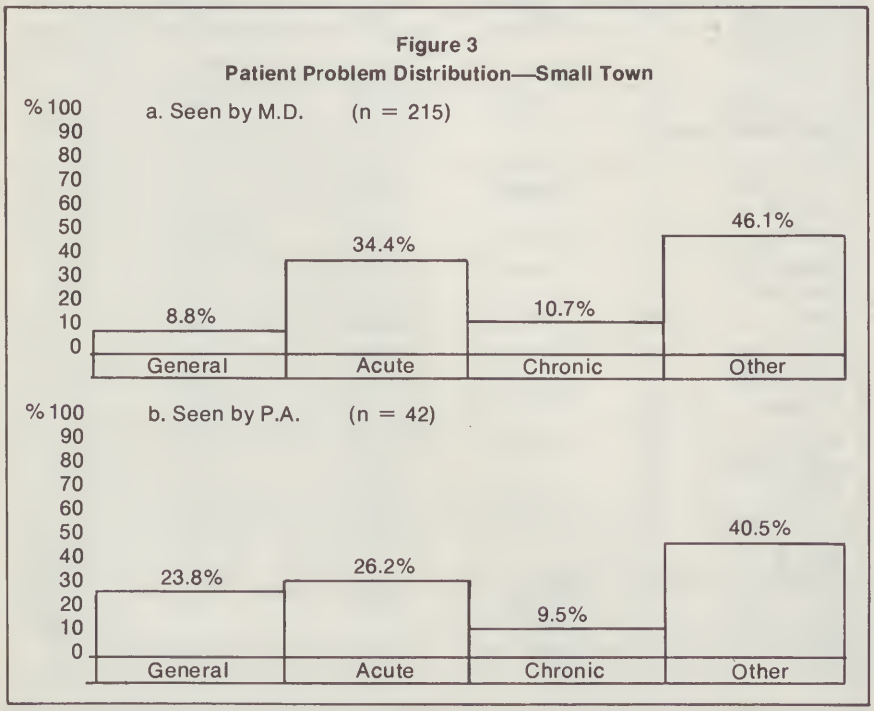
Comparison of Effective Physician Time with and without the Physician's Assistant According to Age and Sex of Patient

	No. of Pts.	P.A. Attendance	Mean Phys. Time (min.)	Mean P.A. Time (min.)	Inc./Dec. Phys. Time
Phys. #21 Age: 45-64 Female	2	w/out	12.5	0	-5.6%
	4	with	11.8	18.8	
Phys. #21 Age: 25-64 Male	2	w/out	18.5	0	-46.0%
	2	with	10.0	15.0	
Phys. #22 Age: 25-44 Female	5	w/out	10.8	0	-35.2%
	5	with	7.0	14.8	
Phys. #22 Age: 45-64 Female	7	w/out	8.1	0	-13.6%
	3	with	7.0	8.7	
Phys. #22 Age: 45-64 Male	2	w/out	10.0	0	-55.0%
	2	with	4.5	13.5	
Phys. #22 Age: 65+ Female	2	w/out	13.5	0	-63.0%
	1	with	5.0	15.0	
Phys. #22 Age: 65+ Male	2	w/out	8.0	0	-8.8%
	4	with	7.3	10.8	
Phys. #23 Age: 45-64 Female	7	w/out	12.6	0	-42.1%
	3	with	7.3	14.7	
Phys. #23 Age: 45-64 Male	5	w/out	15.4	0	-31.8%
	4	with	10.5	16.8	
Phys. #23 Age: 65+ Female	4	w/out	17.5	0	-51.4%
	2	with	8.5	18.5	
Phys. #23 Age: 65+ Male	5	w/out	15.6	0	-19.9%
	2	with	12.5	20.0	



tice, indicated little difference in the patient age groups seen.

The third hypothesis was that the type of patient problem would cause variation in the impact of the physician's assistant. Figure 2, subject to the limitations described above, presents the usable data for the medical center practice. A similar comparison was made of the types of problems seen by the physician's assistant and the physician in the small-town practice during the same period (Figure 3). Because the sample was small in light of the variety of problems to be handled, the problems were aggregated according to category: acute, chronic, and general. In the medical center practice, the physician's assistant saw all the "general" patients which was a very small percentage of the practice. The physician saw about 70 percent more of the chronic patients. The small-town practice saw more "acute" and "general" problems. The physician's assistant saw more than two and a half times the "general" than did the physician.



The study was conducted at two different sites and was superimposed on the normal activity. Relying on the clinical staff meant that results would be subject to the site conditions. The medical center group practice was staffed by Hahnemann physicians interested in the success of the physician's assistant program. These physicians were committed to the principle that the preceptorship was a learning experience. They used the office setting as a teaching vehicle since their contact with the physician's assistant immediately before and after office hours was minimal. Thus, while one might suspect that the physicians would utilize the physician's assistant effectively, some of the time saved was reduced by time spent teaching.

Empirically, according to the supporting staff, the physician's assistant reduced the necessary time for new patients in particular because he performed the physical examination and recorded the history while the physician was seeing another patient. This reduced the physician time for the routine work-up and the patient waiting time for the physician. One obstacle in reducing physician time in this practice setting is exemplified by the case of the patient who is referred to a medical center with a more complex problem or the case where the patient perceives his problem as being more complex. Thus, the physician cannot reduce his participation time below a certain minimum.

An initial examination of the encounter forms from the small-town practice indicates that the physician's assistant had seen almost all of his own patients alone, consequently reducing effective physician time expended per patient to zero. This unexpected finding changed the original study conditions, and thus no comparison could be made of the reduction in physician time between sites. The

physician's assistant stated that the physician had contact with one of his patients per four-hour session. There were no consultations recorded for the sample period, however. In this practice, the physician's assistant saw patients for one session of office hours per day and made rounds at the hospital both alone and with the physician.

The physicians in the small-town group practice site had no formal connection with the program prior to accepting the physician's assistant but were interested in his potential usefulness. The fact that the physician's assistant was permitted to see patients on his own after a six-month period confirms his effectiveness. Another indication of his success is that he was invited to join this practice after graduation and is now working there.

This study suggests further investigation into utilization of the allied health professional. Encounter data gathered in other settings such as outpatient clinics and chronic care facilities can provide additional documentation to either support or disprove the efficacy of the allied health professional in delivering primary health care. □

The authors were all affiliated with the department of medicine at Hahnemann Medical College and Hospital at the time of this study. Ms. Lasdon is an instructor in the department of medicine and coordinator of research and evaluation of the Physician's Assistant Program. Dr. Mark, now in private practice, was assistant professor in the department of medicine and clinical coordinator of the Physician's Assistant Program. Dr. Major is associate professor in the department of medicine, director of the division of allied health, and was medical director of the Physician's Assistant Program. Dr. Oaks is professor and chairman of the department of medicine. Dr. Kretzing is in private practice in Carlisle and holds an appointment as clinical assistant professor in the College of Allied Health at Hahnemann. *The program is supported by the National Institutes of Health, Bureau of Health Manpower Education. The authors wish to thank George M. Fitchko for his assistance with the data tabulation—and Peter Sigmann, M.D., H. Robert Gasull, M.D., and Robert A. Hollen, M.D., as well as Ronald Rejzer and Bruce Kipp, physician's assistants, for their participation in this study.*

TRAUMA!

Beware the bruised heart

WILLIAM E. DeMUTH, JR., M.D.
A. JAMES LIEDTKE, M.D.
Hershey

Most heart injuries due to penetrating chest wounds are highly dramatic and readily diagnosed as soon as the victim is examined. Much less apparent are cardiac injuries, principally myocardial contusions, which result from nonpenetrating chest trauma (Figure 1).[1] Such lesions may go unrecognized until too late, leading to death from uncontrollable arrhythmias and acute congestive heart failure.

In modern society, most myocardial contusions derive from sudden decelerations in vehicular collisions.[2] Steering wheel impact injuries to the midchest and sternum may cause violent intrathoracic compressions serious enough to bruise the heart. Since this kind of trauma is commonly associated with other, more obvious, injuries to the viscera, musculoskeletal, and nervous systems, damage to the heart is usually the least suspected. General anesthesia and aggressive major surgery for correction of other injuries in the immediate period following trauma are, therefore, potentially dangerous and may prove fatal because of the stress imposed on a bruised and weakened myocardium made prone to electrical and mechanical instability. Thus conservative management, particularly in the

The authors are from the departments of surgery and medicine at the Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

Figure 1. Illustration of myocardial contusion on anterior surface of the heart. Arrow points to a superficial laceration.

treatment of most fractures (at least temporarily) may, in fact, be life saving.

At least 70 percent of patients with myocardial contusions complain of pain identical to that of angina pectoris or coronary insufficiency (although this may be obscured if accompanied by coexisting chest wall injuries). Almost all victims with cardiac involvement have a tachycardia (greater than 90 beats/minute) and by electrocardiography, demonstrate widespread ST-T wave changes in most leads. Rarely, "J" point elevations are also observed, suggesting a current of injury pattern and should always raise the possibility of damage to one or more cornary arteries.

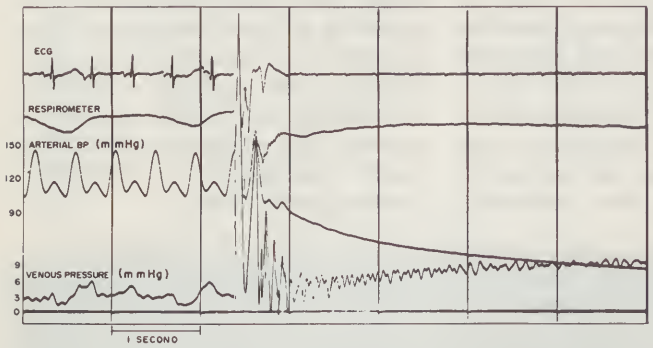


Figure 2. An example of the severe changes in electrical and mechanical functions which occurred following closed chest injury. In this animal, acute development of complete heart block was recorded.

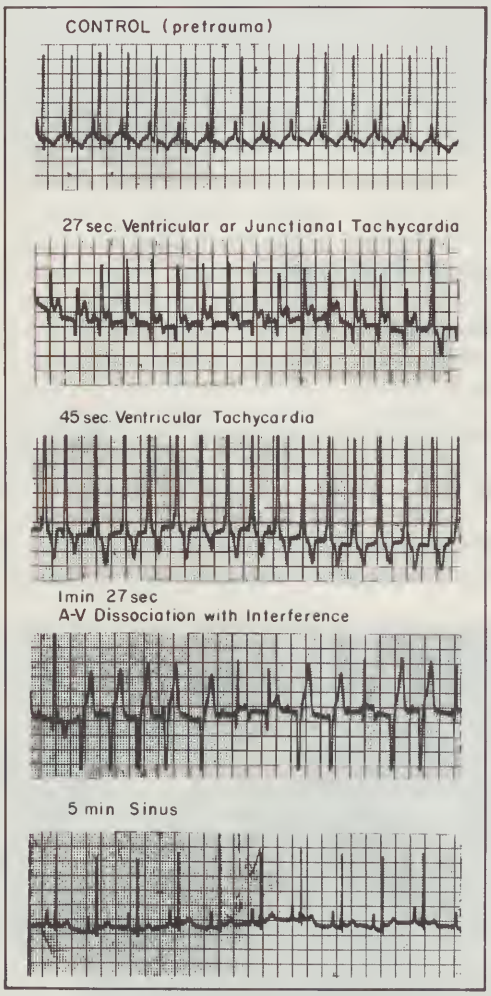


Figure 3. A recording of the major arrhythmias which can occur with myocardial contusion. Note the current of injury pattern in the second panel from the top. This animal ultimately reverted to sinus mechanism at five minutes.

Arrhythmias and disorders of conduction are major findings in cardiac contusions. The most frequent include: (1) premature ventricular contractions (by far the most common); (2) supraventricular tachyarrhythmias including atrial tachycardia, flutter, and fibrillation; (3) varying degrees of atrio-ventricular heart block and dissociation; (4) bundle branch blocks; (5) ventricular tachycardia and fibrillation; and (6) complete cardiac standstill.

A model in dogs for evaluating cardiac injury in nonpenetrating chest trauma has recently been developed in our laboratory[3,4] and confirms the major hemodynamic and electrical alterations which result from such injuries. Figure 2 shows the catastrophic derangements in blood pressure and the electrocardiogram which occurred following a closed-chest impact. Figure 3 illustrates the variety of arrhythmias which may follow closed-chest trauma.

Other laboratory studies, particularly blood assays for serum enzymes, are usually not helpful, largely because of associated injuries and shock.

Treatment for myocardial contusions is identical to that prescribed for myocardial infarction and includes: (1) *bed rest*—usually one to three weeks followed by graded ambulation; (2) *drugs*—only supportive; digitalis should only be given to control supraventricular tachycardias and congestive heart failure; vasodilators offer no benefits, and anticoagulants are often contraindicated because of associated injuries; (3) *oxygen*, if needed, for cyanosis, dyspnea, and congestive failure.

Summary

Myocardial contusions are serious and often unrecognized injuries resulting from nonpenetrating chest trauma. Complaints of angina-like chest pain and tachycardia are often present, and electrocardiography should be performed in all patients for the purpose of documenting major arrhythmias and to serially evaluate ST-T wave changes. General anesthesia and other stresses should be avoided (if at all possible) in the immediate period following injury, especially if alternative forms of treatment are available for associated injuries.

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4. **Liedtke, A. J.; Gault, J. H.; DeMuth, W. E.** Electrocardiographic and hemodynamic changes following nonpenetrating chest trauma in the experimental animal. Amer J. Phsiol. (in press).

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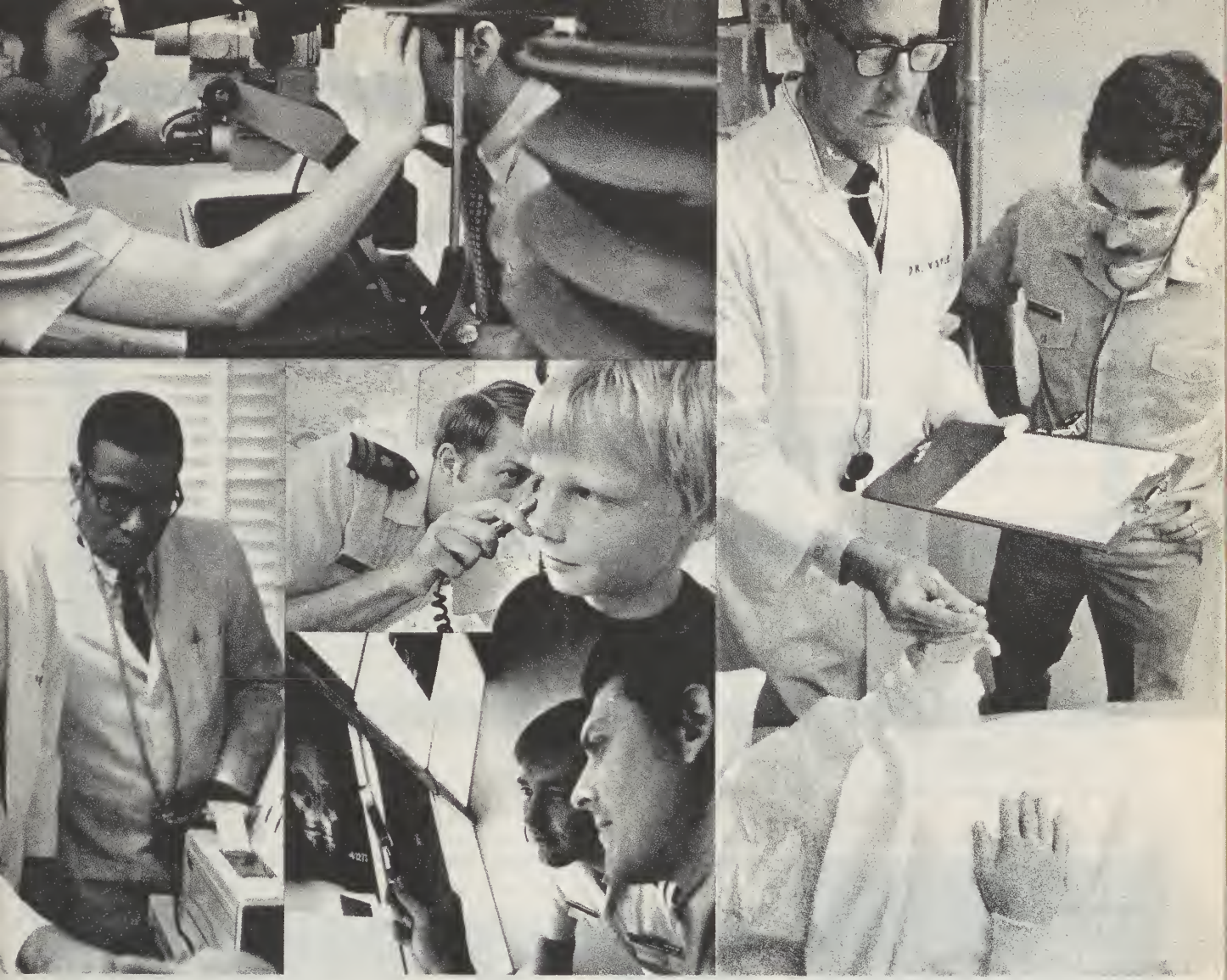
Preliminary Call to the 1974 Annual Session House of Delegates

The 1974 Annual Session of the House of Delegates of the Pennsylvania Medical Society will be called to order at the William Penn Hotel, Pittsburgh, Pennsylvania, on Thursday, October 10, 1974. The second session of the House of Delegates is scheduled for Friday, October 11, 1974. The third and concluding session of the House of Delegates will be held Saturday, October 12, 1974. Since the third session may last into mid-afternoon, delegates should plan accordingly.

All proposed amendments to the Constitution must be submitted to the office of the Secretary of this Society on or before June 10, 1974. Such amendments may be proposed upon the written petition of 15 active, senior active, or resident or intern members of the Society, or by the Committee on Constitution and Bylaws. While there is no specific requirement that Bylaw amendments be submitted in advance or published in the Official Call, this is preferable when possible. Written resolutions to be considered by the House may be submitted to the Secretary by a delegate acting in his own behalf or for the component county medical society or specialty society he represents. If received prior to September 10, 1974, they will be published in the Official Reports Book.

Charles E. Schlager, M.D.
Secretary



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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Dan G. Bierer,** Carnegie; University of Maryland School of Medicine, 1935; age 67; died January 18, 1974. He had practiced medicine in Delmont for thirty years and for the past seven years had been a resident physician at Woodville State Hospital. He is survived by his wife and two daughters, one of whom is Rosalie Bierer Kryston, M.D., Philadelphia.

• **Joseph J. Callaghan,** Philadelphia; Temple University School of Medicine, 1927; age 75; died November 8, 1973. No further information is available.

• **Carl H. Campbell,** Charleston, S.C.; Jefferson Medical College, 1917; age 80; died December 2, 1973. No further information is available.

• **Erwin G. Degling,** Lewisburg; Hahnemann Medical College and Hospital, 1941; age 68; died February 20, 1974. No further information is available.

• **Alfred Dinert,** Philadelphia; Medical Faculty of the University of Vienna, Austria, 1933; age 69; died February 9, 1974. He had practiced medicine in Philadelphia for thirty-four years. He is survived by his wife, two daughters, a sister, and a brother.

• **John W. Egoville,** Philadelphia; Temple University School of Medicine, 1933; age 65; died January 25, 1974. He was on the staff of the Graduate Hospital and Presbyterian Hospital, Philadelphia. He was a fellow of the American College of Surgeons and was secretary and regent of the International College of Surgeons. Survivors include his wife, two sons, and a brother.

• **Robert R. Garison,** Williamsport; Medical College of South Carolina, 1946; age 51; died February 16, 1974. He is survived by his wife; a daughter; a son; three sisters; and two brothers, one of whom is Gary Garison, M.D., Fayetteville, N.C.

• **Leonard C. Hamblock,** Nakomis, Florida; University of Pennsylvania School of Medicine, 1925; age 74; died January 26, 1974. He was formerly chief of obstetrics and gynecology at the Methodist Hospital, Philadelphia, and a former medical director of the Masonic Home at Elizabethtown. Dr. Hamblock was a diplomate of the American Board of Obstetrics and Gynecology, a founding fellow of the American College of Obstetricians and Gynecologists, and a fellow of the American College of Surgeons. He is survived by his wife.

• **Howard M. Keebler,** St. Marys; Temple University School of Medicine, 1940; age 58; died January 13, 1974. He was head of the obstetrics department at the Andrew Kaul Memorial Hospital. He is survived by his wife, two daughters, and two sons.

• **William P. Kenworthy, Jr.,** Atglen; Jefferson Medical College, 1934; age 76; died September 1, 1973. His wife survives him.

• **John B. Laughrey,** Sutersville; Jefferson Medical College, 1908; age 92; died February 3, 1974. He had practiced medicine for sixty-three years. There are no immediate survivors.

• **Joseph L. Magrath,** Drexel Hill; Jefferson Medical College, 1927; age 77; died January 17, 1974. He was a fellow of the American College of Surgeons and the International College of Surgeons. Survivors include his wife; two sons, one of whom is Joseph Magrath, Jr., M.D., Upper Darby; and a brother.

• **Noah K. Mack,** Morgantown; Hahnemann Medical College and Hospital, 1937; age 62; died January 15, 1974. His wife, three daughters, a sister, and his mother and father survive him.

• **James L. Martin,** Philadelphia; Leonard Medical School, Raleigh, N.C., 1906; age 92; died January 25, 1974. He had practiced medicine in South Philadelphia for more than fifty years and served as an instructor in x-ray and radiology at Howard University. Information regarding survivors is not available.

• **P. Ralph Meloro,** Broomall; University of Pennsylvania School of Medicine, 1940; age 58; died January 12, 1974. He was a fellow of the American College of Obstetrics and Gynecology and an associate professor of obstetrics and gynecology at Jefferson Medical College. He is survived by his wife, two daughters, a son, two brothers, and three sisters.

• **Dan Phythyon,** Sharon; Johns Hopkins University School of Medicine, 1918; age 83; died December 26, 1973. He was formerly head of the department of obstetrics and gynecology at Sharon General Hospital. Dr. Phythyon was certified by the American Board of Obstetrics and Gynecology and was a past president of the Mercer County Medical Society. Survivors include his wife; a daughter; and two sons, one of whom is James M. Phythyon, M.D., Nashville, Tennessee.

• **Norwin A. Rosen,** Pittsburgh; University of Pittsburgh, 1949; age 51; died January 7, 1974. He had practiced medicine in East Liberty for twenty-seven years. He was a fellow of the Pennsylvania Society of Ophthalmology and Otolaryngology. His wife; two daughters; a son; a sister; and a brother, Samuel J. Rosen, M.D., Pittsburgh, survive him.

• **Yasohichi F. Yoshida,** Ardmore; Jefferson Medical College, 1927; age 73; died January 27, 1974. He was a fellow of the American College of Surgeons, and a member of the American College of Obstetricians and Gynecologists. He is survived by his wife, four daughters, two sons, two sisters, and two brothers.

Eugene M. Hartnett, Newtown Square; Georgetown University School of Medicine, 1939; age 60; died September 11, 1973. He is survived by his wife.

Charles A. Shillott, Harrisburg; Jefferson Medical College, 1915; age 82; died December 5, 1973. He is survived by a daughter, a son, and two sisters.

Forrest H. Battis, M.D., Philadelphia; Howard University School of Medicine, 1907; age 89; died February 9, 1974. He had practiced medicine in Philadelphia for sixty-six years. His wife survives him.

continuing education

This issue carries no education course listings. New listings will be published in the May issue. Copies of the lists published in the December, January, and March issues and typed copy of new listings received since then are available from the Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

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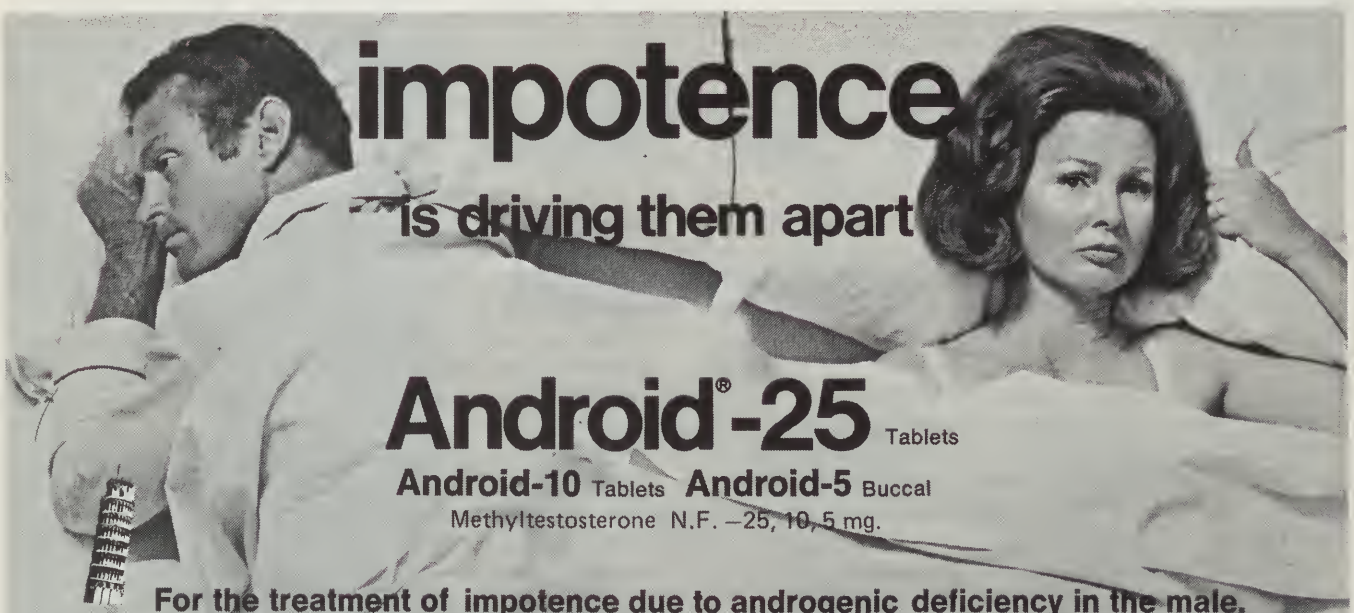

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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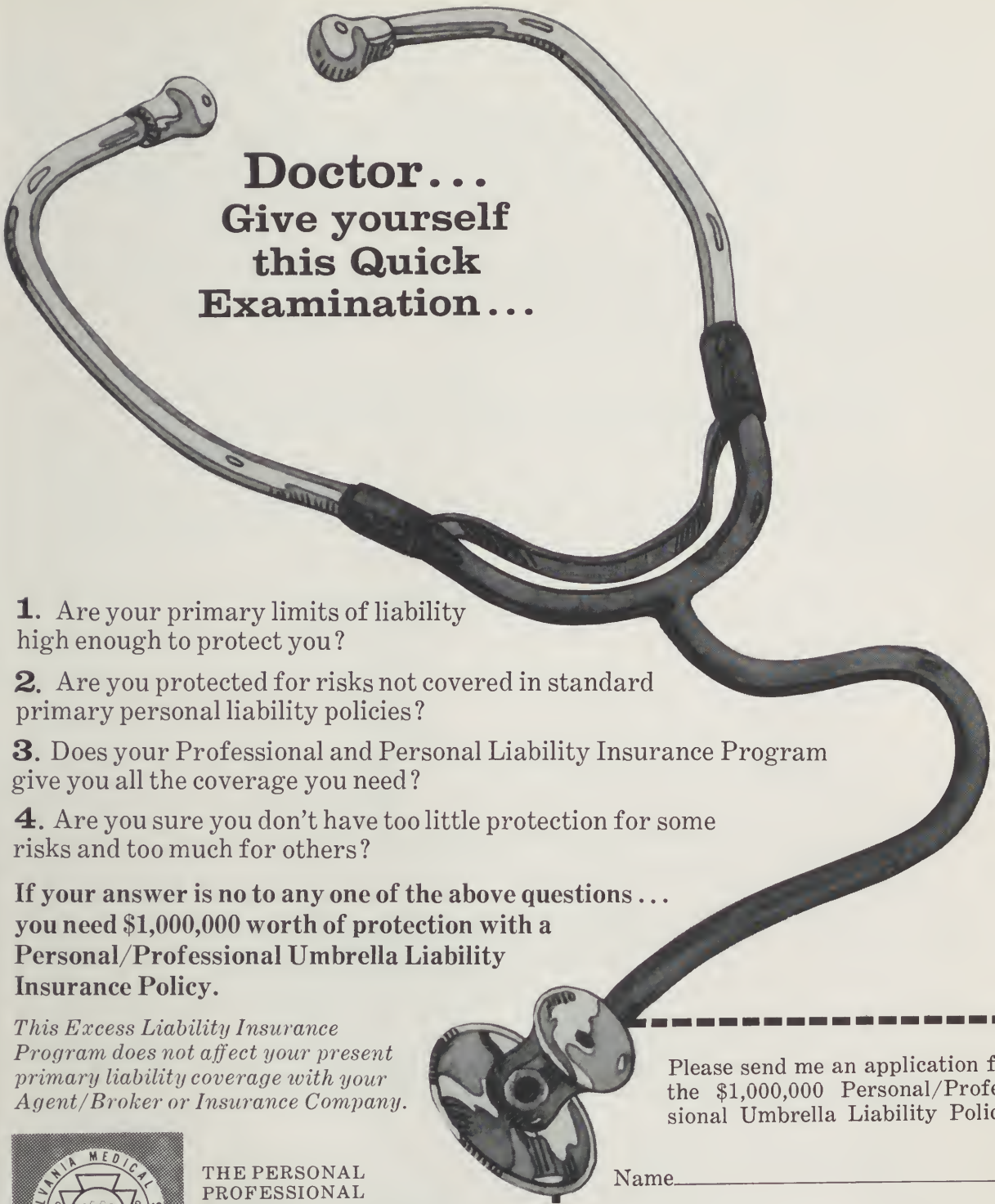

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

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1 *Synthroid* is T4.

2 Because T4 converts to T3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1, 2]

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4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

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6 *Synthroid* is the most prescribed brand name of thyroid in the U. S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

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(sodium levothyroxine)

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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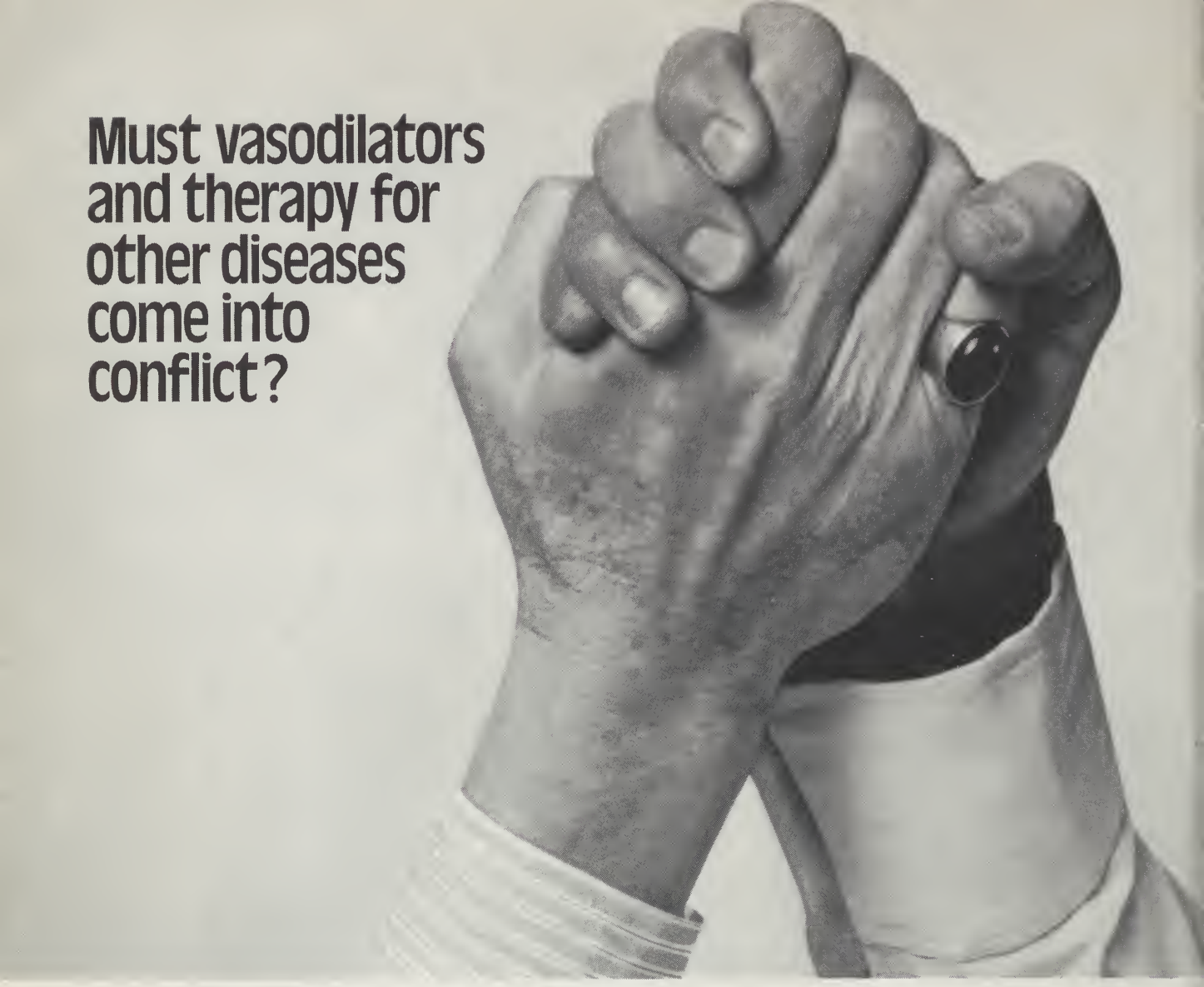
Must vasodilators and therapy for other diseases come into conflict?



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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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- in cystitis, pyelonephritis and pyelitis diagnosed as chronic
- against susceptible strains of the common urinary tract pathogens, usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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Before prescribing, please consult complete product information, a summary of which appears on preceding page.

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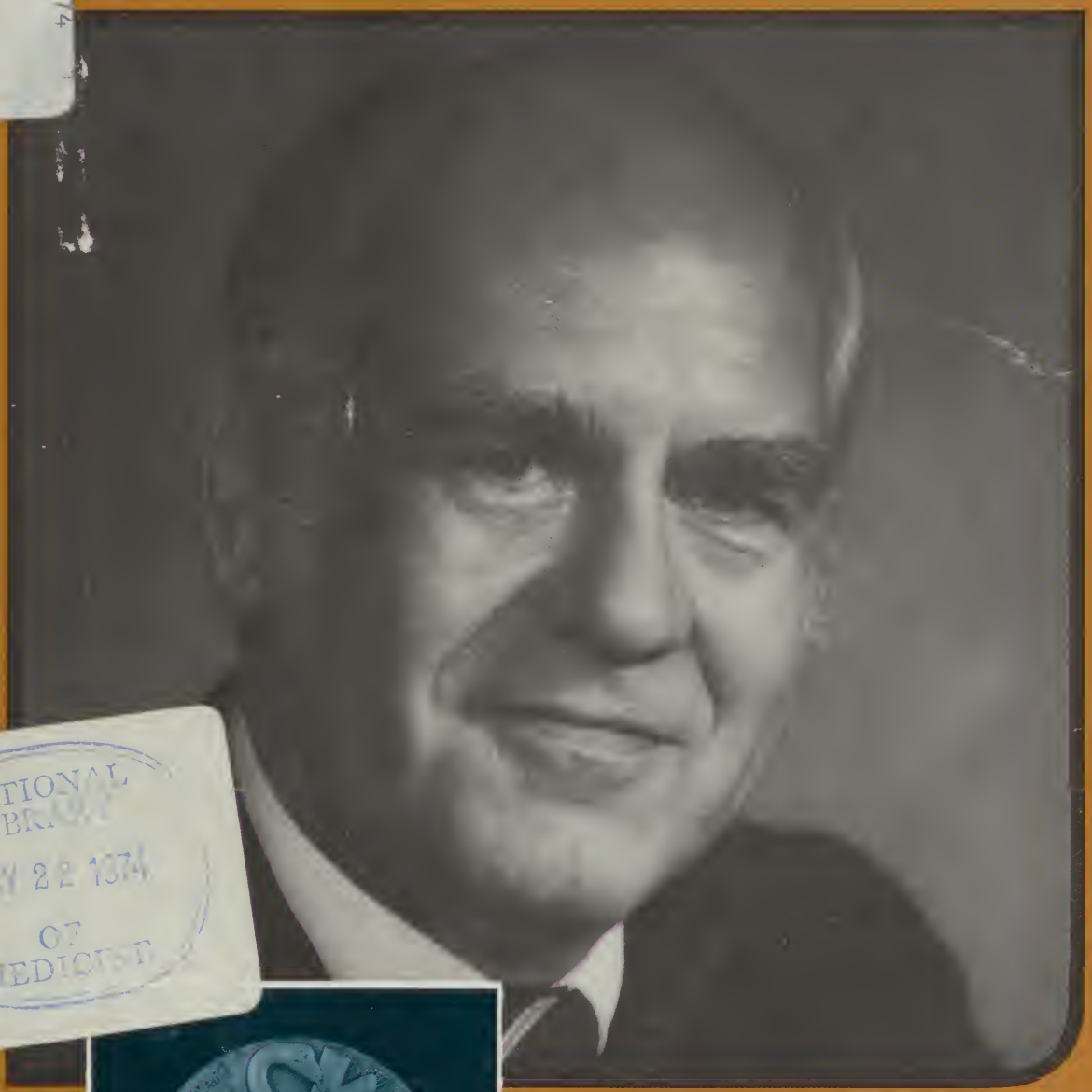

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medigram

May 1974

1974 OFFICERS' CONFERENCE SETS RECORD

A record attendance of 290 was registered for the 1974 Officers' Conference at the Host Inn, Harrisburg, April 24 and 25. Delegates heard reports on family physician distribution, PaMPAC, the Society's continuing medical education requirement, and Professional Standards Review Organizations. Executive Vice President John F. Rineman launched the conference with an illustrated "report to the stockholders." All councilor districts met during the conference, as did several committees, two councils, Pennsylvania's AMA delegation, the Pennsylvania Medical Care Foundation Board of Directors, and the Board of Directors of the Pennsylvania Medical Political Action Committee. Society President Ralph C. Wilde presided at the Wednesday evening banquet featuring political humorist Mark Russell, of Washington, D.C. The conference concluded with an address by President Wilde.

INSURANCE DEPARTMENT SETS HEARINGS

The Pennsylvania Insurance Department will conduct informal hearings in Philadelphia in June to gather information on the performance of malpractice insurers in the field of loss prevention. William J. Sheppard, acting insurance commissioner, said, "The time has come for a comprehensive review of the role of...insurers in halting the upward trend of malpractice suits." Meanwhile, Aetna Casualty and Insurance Co., which covers about 1,200 Pennsylvania physicians for professional liability, has withdrawn its recent rate increase request. Other insurers in the field have submitted rate increase requests, but hearings on these have not been announced. No increase in rates has been requested at this time for the professional liability insurance program sponsored by the State Society, underwritten by Argonaut Insurance Co., and administered by Parker and Co. of Pennsylvania. Approximately one-third of the Society's members are covered by the program and are receiving Argonaut's educational materials regularly. Representatives of the State Society will appear at the June hearings.

SENATE PASSES BATTERED CHILD BILL

The Pennsylvania Senate late in April unanimously passed S.B. 1166, which would require reporting of all suspected cases of child abuse, and sent it to the House of Representatives, where it was referred to the Committee on Health and Welfare. The bill provides penalties up to ninety days in jail for failure to report cases, but also makes immune from civil or criminal damages those medical, hospital, school, law enforcement, or other child care personnel who report as required.

AMBULATORY GYNECOLOGICAL SURGERY RULES WITHDRAWN

The Pennsylvania Department of Health will rewrite recently withdrawn proposed regulations governing ambulatory gynecological surgery in hospitals and clinics which were criticized as too restrictive by the State Society through comment from James A. Collins, M.D., chairman of the Council on Education and Science. The Department has requested Society assistance in rewriting the regulations.

HAP-PMS ISSUE 'JOINT COMMUNIQUE' Hospital officials throughout Pennsylvania received in April a letter from Ralph C. Wilde, M.D., State Society president, and Milton H. Appleyard, chairman of the Board of Trustees of the Hospital Association of Pennsylvania, expressing the concern of both associations in the matter of holding down cost of hospitalizations. In keeping with the Society's Resolution 73-25, the letter requests that hospitals make staff members aware of the cost of hospitalization through such techniques as placing a copy of each patient's bill in the physician's mailbox.

AMA VIDEO SHOW SCHEDULED HERE The AMA's latest effort at public education on health--a television production based on the magazine, Today's Health--can be seen in Pennsylvania on KDKA, Pittsburgh, Sundays at 12:30 p.m., beginning May 19; and on WCAU, Philadelphia, Saturdays at 2:30 p.m., beginning June 2.

HEW ANNOUNCES FURTHER PSRO PROCEDURES HEW Secretary Caspar Weinberger announced April 16 the procedure through which the Department of Health, Education, and Welfare will assure that the Professional Standards Review Organizations authorized in the various geographic areas represent the physicians of the area. Before entering into an agreement with an organization seeking to be the PSRO, the department must notify area physicians and take steps to determine that the organization is acceptable to area physicians. The method to be used was published in the Federal Register, and will, the secretary said, assure that "it is the local physicians who will plan, operate, and control the PSRO in each area." Details will appear in the June issue of PENNSYLVANIA MEDICINE.

HYPERTENSION SCREENING SERVICES OFFERED The Pennsylvania Department of Health has planned free hypertension screening programs at various locations throughout the state during May, which has been declared High Blood Pressure Month in Pennsylvania by Governor Milton J. Shapp (see related article on page 12 of this issue). Educational activities will continue throughout the year as a cooperative effort of the Department of Health, the Pennsylvania Affiliate of the American Health Association, and the Pennsylvania Medical Society. The July PENNSYLVANIA MEDICINE will be a special issue on hypertension.

FOUNDATION OPENS PITTSBURGH OFFICE The Pennsylvania Medical Care Foundation has opened its Pittsburgh office in the Allegheny County Medical Society headquarters. Rose G. Ferraro, R.N., who joined the Foundation staff in April, will work out of that office as a field representative.

REYE'S SYNDROME SEMINAR SCHEDULED Juniata College and the J.C. Blair Memorial Hospital are cosponsoring a seminar on Reye's syndrome at the college on Saturday, May 18, beginning at 9 a.m. Robert E. Brown, M.D., chairman of the department of pathology at the hospital, the main speaker, has gained nationwide recognition for his studies of the disease affecting children. He has prepared a paper on the subject for the June issue of PENNSYLVANIA MEDICINE. Further information on the seminar is available from Dr. Robert P. Zimmerer at the college.

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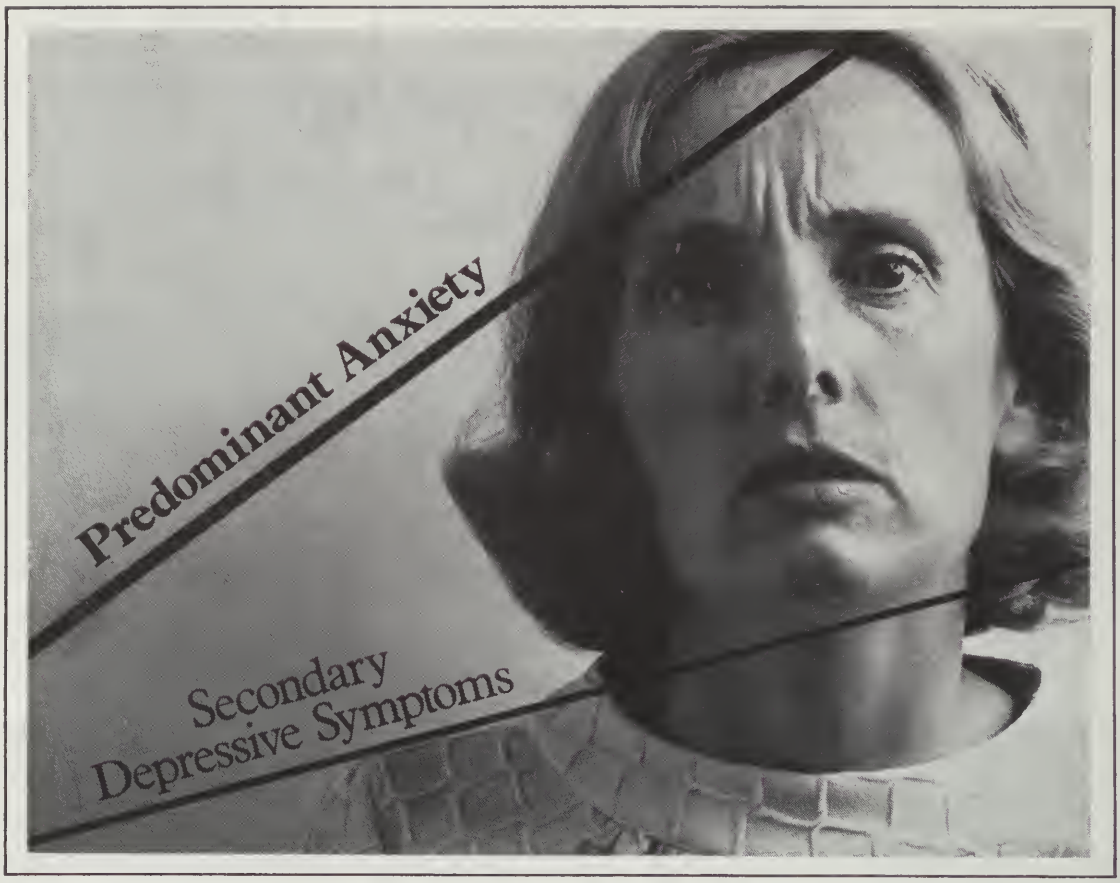

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex
to Valium® (diazepam)

Precautions: If combined with ;her psychotropics or anticonvul-;nts, consider carefully pharma-)logy of agents employed; drugs ıch as phenothiazines, narcotics, ;rbiturates, MAO inhibitors and ;her antidepressants may poten-ıte its action. Usual precautions dicated in patients severely de-ressed, or with latent depression, with suicidal tendencies. Observe ıual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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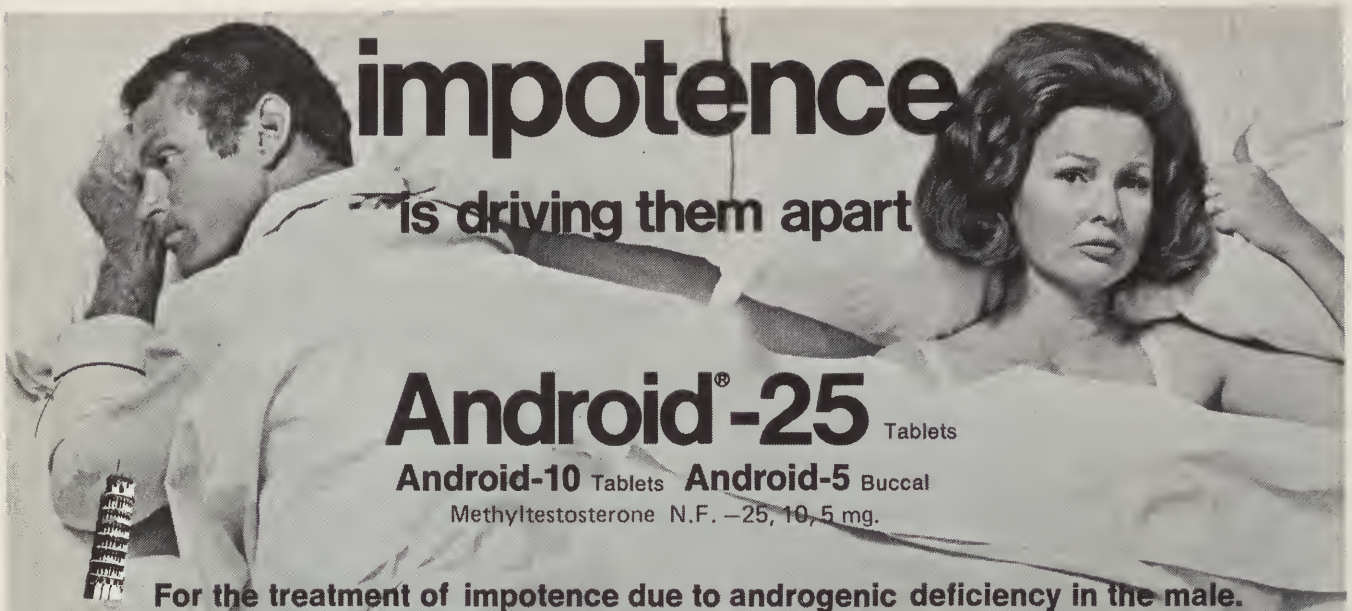

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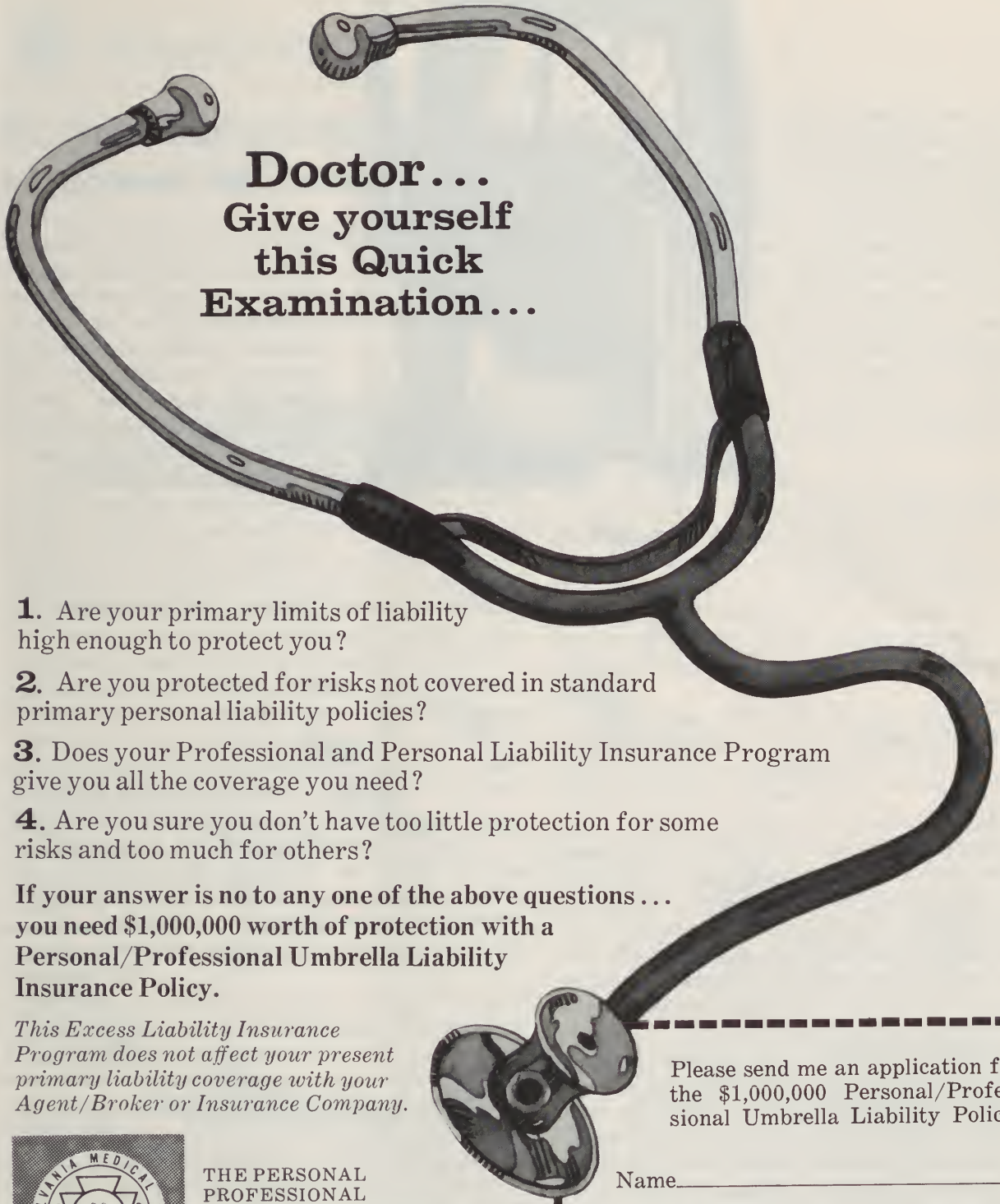

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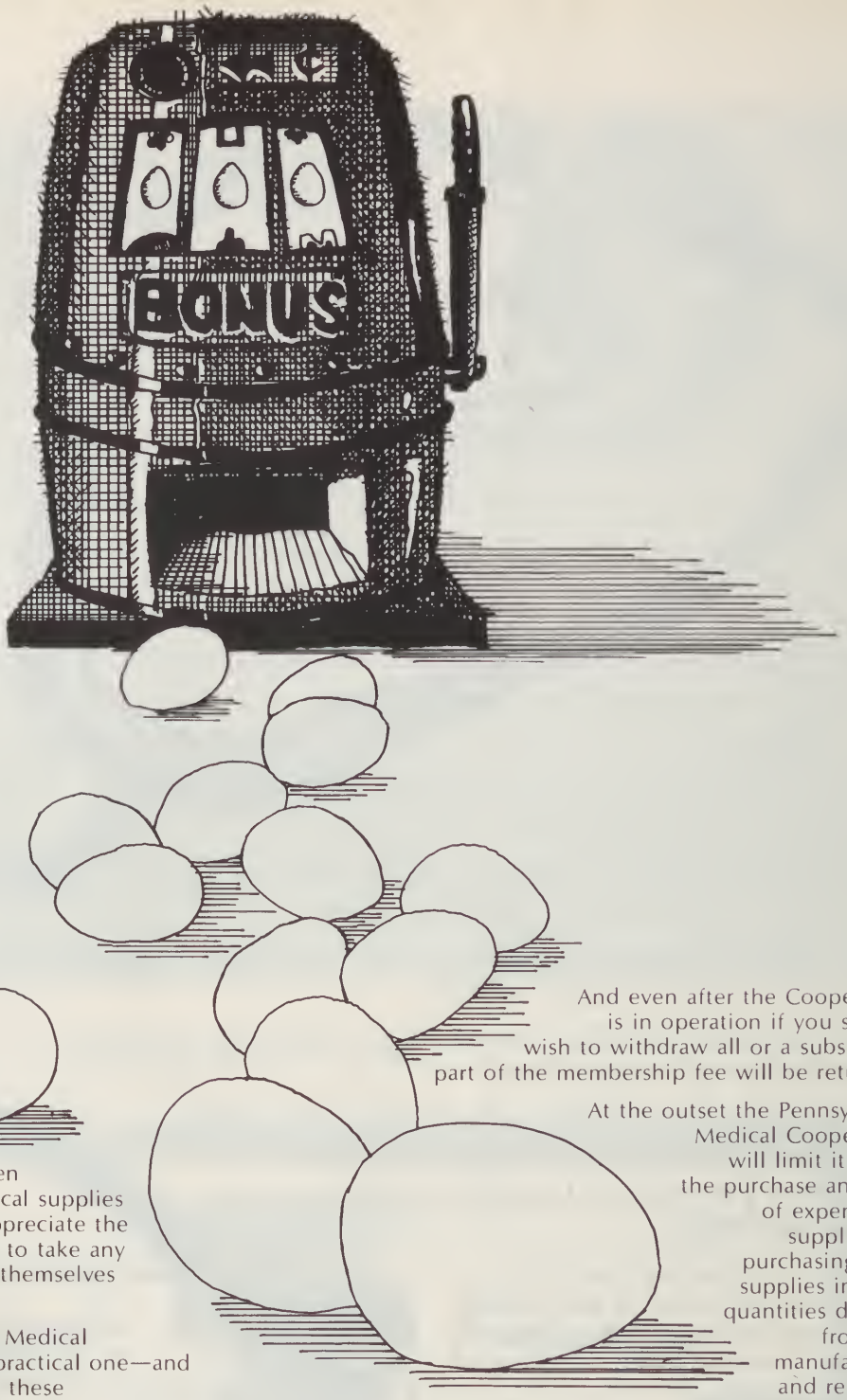

There's no gamble on this investment

Pennsylvania physicians are responding enthusiastically to the proposed formation of a Pennsylvania Medical Cooperative. They feel the Cooperative's cheaper-by-the-dozen approach to the purchase of medical supplies makes a lot of sense. They also appreciate the fact that they are not being asked to take any financial risk whatever in availing themselves of the Cooperative's benefits.

The idea behind the Pennsylvania Medical Cooperative is a very simple and practical one—and one that is especially appealing in these days of rapidly rising costs. What it means is that instead of purchasing supplies in small quantities, individually, the State's physicians will be banding together to make their purchases on a mass basis, in large volume, at significant savings.

Membership in the Pennsylvania Medical Cooperative will be open to Pennsylvania Medical Society members only, through the once-and-done purchase of a modest $100 lifetime share. If the proposed Cooperative should not materialize, the $100 membership fee will be returned in full.

And even after the Cooperative is in operation if you should wish to withdraw all or a substantial part of the membership fee will be returned.

At the outset the Pennsylvania Medical Cooperative will limit itself to the purchase and sale of expendable supplies. By purchasing such supplies in large quantities directly from the manufacturer and reselling them at cost, it is expected that the Cooperative will be able to offer its physician members savings of 30 to 50 per cent. Later, when the Cooperative expands into the field of surgical supplies, office equipment and so on, the potential for savings will be even greater.

The Pennsylvania Medical Cooperative has much to recommend it: an opportunity for substantial savings without any risk whatever, and a chance to simplify your purchasing procedures and take a giant stride toward inventory control. For further information, please write or call.

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Another New Benefit to Members of Pennsylvania Medical Society

Dr. Roth named recipient of highest PMS award

Russell B. Roth, M.D., president of the American Medical Association and a native of Erie, Pa., where he maintains his medical practice, has been named recipient of the Distinguished Service Award of the Pennsylvania Medical Society, Ralph C. Wilde, M.D., State Society president, has announced. Formal presentation will occur at the Society's Dinner October 11, 1974, at the William Penn Hotel, Pittsburgh.

Only four other physicians have received the award since its establishment in 1955. In 1956, Jonas E. Salk, M.D., formerly of Pittsburgh, and now director of the Salk Institute in California, was honored for his contribution toward perfection of poliomyelitis vaccine. In 1962, John H. Gibbon, Jr. M.D., who perfected the heart-lung machine and pioneered in the field of open heart surgery, was honored. Dr Gibbon died suddenly in 1973. James Z. Appel, M.D., of Lancaster, former AMA president, received the award in 1967 in recognition of his outstanding leadership in organized medicine. Most recently, Eugene P. Pendergrass, M.D., of Wynnewood, director emeritus of radiology and radiation therapy at the Hospital of the University of Pennsylvania and professor emeritus at the university's school of medicine, received the award for this contributions in these fields, both nationally and internationally. Dr. Pendergrass received the award in 1970.

Dr. Roth, the 128th president of the AMA, has practiced urology in Erie for almost thirty years. He returned there to join the practice of the late Elmer Hess, M.D., after completing his military service during World War II with the U.S. Army Medical Corps. The son of a surgeon, Dr. Roth's early interest had been in literature and composition. He was attracted to medicine while an undergraduate at Yale University. He pursued his medical studies at Johns Hopkins University School of Medicine and obtained his medical degree in 1939. He stayed on at Hopkins, serving a one-year internship in urology, followed by a year of pathology. Following a year in a general surgery residency at St. Mary's Hospital, Pierre, S.D., he continued his residency in urology, first at Henry Ford Hospital in Detroit and then as senior resident at Brady Urological Institute in Baltimore. Coincidentally, Dr. Hess, who chose Dr. Roth as one of his first partners, preceded him as president of the AMA. Dr. Hess served in 1955.

Early in his career, Dr. Roth put into practice his belief that physicians have an obligation to be activists in medical affairs. He served as president of the Erie County Medical Society, was a member of the Board of Trustees of the Pennsylvania Medical Society for ten years, serving as chairman of the Board for two years, and was speaker of the Society's House of Delegatès for four years. He served the AMA in numerous capacities, including chairmanship of the Council on Medical Service, vice speaker, and speaker of the House of Delegates prior to his election to the post of president elect in 1972.

Dr. Roth is well known in Washington where, pursuing his belief that physicians should speak up on legislative proposals involving medical care, he frequently testifies for the AMA. He has written and lectured widely on his specialty of urology as well as on general medical and socioeconomic issues, and he has acted as an official representative of American physicians in numerous visits to foreign nations.

The 60-year old physician and surgeon shares his hobbies with his wife of nine years, Jeanne. When time permits, they hunt and fish and relax on their houseboat on Lake Erie.

Dr. Roth is a member of numerous professional associations, including the American Urological Association, the American Association of Clinical Urologists, and the Academy of International Medicine. He has served in an advisory capacity on medical affairs to both the state and federal governments and is active in community affairs and local organizations in Erie.

'For his unswerving dedication to the cause of physicians and the welfare of patients and for the excellence of his leadership in organized medicine on the state and national level, the Pennsylvania Medical Society has determined to award to Russell B. Roth, M.D., of Erie, president of the American Medical Association, its Distinguished Service Award.' With these words Ralph C. Wilde, M.D., State Society president, announced the honor to be bestowed on Russ Roth. He is known to his colleagues in Pennsylvania for these virtues, and for more. Respected clinician, outstanding teacher, raconteur, sometimes poet and writer of ditties, vocalist, and doodler of the highest order, he does what he does well.

Foundation funded; nation's first PSRO support center plans aid

A $243,295 one-year contract establishing the Pennsylvania Medical Care Foundation as the nation's first statewide PSRO support center, was announced by the Department of Health, Education, and Welfare (HEW) effective March 29.

Many of the services called for in the contract were already being provided by the Foundation on a limited basis. With the addition of federal funds those services will now be expanded.

"According to the contract, our job basically is to provide professional and technical help to the local PSRO areas in Pennsylvania," said Larry Fosselman, executive director of the Foundation.

"We've been providing that help to the extent that we were able with PMS funds. The addition of the federal money will allow us to expand the Foundation staff to a total of ten people and to open field offices in Pittsburgh and Philadelphia," he explained.

"As a first step, we'll assist them in preparing applications for PSRO planning contracts for submittal to HEW. That in itself is a major undertaking," Fosselman said. Proposals for these contracts must include the development of a formal plan for the operation of a PSRO including review systems, organizational structures, and membership requirements.

"Once these six-month planning contracts are awarded, we'll then assist the PSROs in carrying out the contract requirements. We'll help them develop organizational structures, which include the writing of formal bylaws. We'll also assist in developing and implementing formal review procedures in the PSRO areas," Fosselman added.

Under the terms of the contract, the Foundation as a statewide PSRO support center will also provide PSRO areas with the administrative assistance needed to get each organization off the ground. "This includes management and personnel advice; helping in the preparation of job descriptions; staff recruitment; salary administration; performance appraisals; and developing accounting and bookkeeping systems—things such as that," Fosselman said.

"But we'll also provide professional advice to the local organizations through our physician consultants," Fosselman said. "This advice will include the interpretation of federal guidelines and regulations to fit situations in individual areas, as well as advice on recruiting members for the PSRO and methods of peer review," he added.

The HEW contract also requires the Foundation to provide advice and support to hospital utilization review committees.

"We'll be contacting a select group of hospitals, probably about thirty altogether, to offer assistance. Basically our function here will be to insure that these hospitals and hospital utilization review committees will meet the requirements for utilization and quality review under the PSRO law."

"Since we are the first organization to be designated as a statewide PSRO support center, our activities will serve as a model for PSRO support centers that might be funded in other states," said Fosselman. "Thus the role we develop as a support center will no doubt have a great impact on the entire PSRO program."

CLAUDE NICHOLS, M.D., (second from left), president of the Dauphin County Medical Society (DCMS), greets Michael Rosenstein, research director for the Health and Welfare Committee of the Pennsylvania House of Representatives, who discussed legislation as it affects medical practice at a county society dinner meeting last month. Joseph Ichter, M.D., (far right), DCMS program chairman, and Robert H. Craig, director of governmental relations for the State Society, appear with them.

S. B. 1326 calls for health facility reporting, licensing, cost approval

What does the future hold for Senate Bill 1326, "The Comprehensive Health Care Act," introduced November 28, 1973, and referred to the Senate Health and Welfare Committee, which has since then conducted extensive hearings at various locations in the state?

The answer is anybody's guess, but the recent introduction in the House of Representatives of H. B. 2018, "The Health Care Facility Cost Containment Act," which covers much the same ground, is an indication that, although S. B. 1326 may pass the Senate, it will not move in the House, which now has its own legislation covering the area.

S. B. 1326 was developed from the governor's comprehensive health care act, S. B. 863, which was formally opposed by the State Society policy decision made when the 1973 House of Delegates voted to oppose it and its companion, H. B. 987.

Senate Bill 1326 proposes to do the following:

1. Establish a Health Care Policy Board in the Department of Health to guide a unified system of regulation of health care providers with four mechanisms: (a) certification of need; (b) licensing; (c) uniform accounting and reporting; and (d) rate approval. The policy Board would consist of nine members, a majority of whom must be consumers. The secretary of health would be a member ex officio and would serve as chairman. Other members would be appointed by the governor for staggered terms of four years each.

2. Place regulatory powers in the health care field—those already existing and others which would be established by the bill—in one agency, the Department of Health, to be governed by policies established by the Health Care Policy Board. The regulatory powers of the bill cover all hospitals, intermediate care facilities, skilled nursing homes, ambulatory surgical centers, and rehabilitation facilities. Specifically excluded are offices used exclusively for private practice.

3. Have medicare regulations interpreted by the health department rather than by the fiscal intermediary.

4. Establish the position of health advocate, to be appointed by the governor for four years and represent interests of users.

5. Demand that health care facilities, in order to obtain a license, have a valid certificate of need—all facilities presently licensed or approved would be issued a certificate; construction or alterations costing more than $100,000 would require an amendment to the certificate.

6. Require that all health care facilities be licensed by the department and that licenses be renewed every three years.

7. Require uniform accounting and reporting, with approval of all rates to be paid to health care providers to follow after a data base is established.

8. Grant the department the right to seek an injunction against someone operating a health care facility without a license or violating the provisions of the act.

9. Appropriate one and one half million dollars to implement the bill.

The State Society's testimony on the bill, reported in the April issue, pointed out that the Society supports licensing of hospitals, uniform accounting, and certificate of need, but that the Board of Trustees had taken a position that legislation on the federal level (Section 221 of Public Law 92-603) provides penalties sufficient to guarantee containment of costs and to prevent construction of unneeded facilities.

A NEW BILL, H. B. 2018, "The Health Care Facility Cost Containment Act," was introduced in March and became the subject of April hearings before the House Committee on Health and Welfare. Shown at the hearings are, left to right, Robert H. Craig, Jr., director of governmental relations; John F. Rineman, executive vice president, who testified for the Society; and Jerry Rothenberger, PaMPAC director.

Society cosponsor

May named high blood pressure month

Governor Milton J. Shapp signed a formal declaration on April 30, 1974, designating May as High Blood Pressure Month in Pennsylvania as part of a nationwide effort to spearhead an educational program on high blood pressure and its dangers. The Pennsylvania Medical Society is cosponsor of the public education effort.

The proclamation urges all citizens to have their blood pressure checked to encourage the early detection and treatment of the disease. The governor said, "Statistics suggest nearly two million Pennsylvanians have high blood pressure, and half of them are unaware of it."

Major agencies participating in the public education program include the American Heart Association's Pennsylvania affiliate, the Pennsylvania Department of Health, the Pennsylvania Medical Society, and many other medical, health care, and voluntary groups.

Nationally the American Heart Association; the American Medical Association; the American Red Cross; the U.S. Department of Health, Education, and Welfare; the National Medical Association; and Citizens for Treatment of High Blood Pressure are cooperating with pharmaceutical companies, community and local agencies and groups, and newspapers, television, and radio stations in disseminating information on screening programs, educational programs, and films.

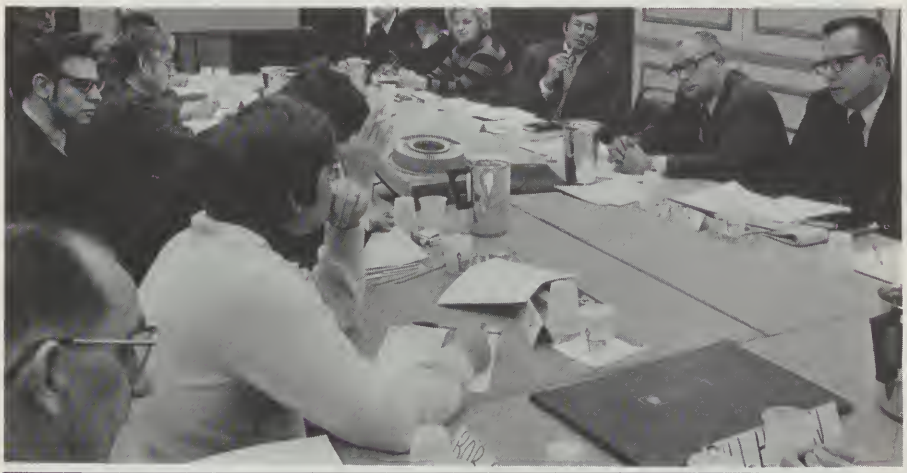
Dr. Flannery heads Blue Shield trustees

Wilbur E. Flannery, M.D., of New Castle was elected chairman of the Blue Shield Board of Directors at the annual meeting of the Blue Shield Corporation on April 17. A past president of the State Society, he succeeds Allen W. Cowley, M.D., who declined nomination for reelection. Lewis T. Buckman, M.D., Wilkes-Barre, was reelected first vice chairman, and Arthur M. Flack, D.O., Harrisburg, was named second vice chairman.

William Y. Rial, M.D., Swarthmore, vice speaker of the AMA House of Delegates and former speaker of the State Society House, was elected to the Board of Directors to succeed William R. Hunt, M.D., Pittsburgh, whose term expired. Five physicians were among eight reelected board members. They are Dr. Buckman; John F. Drumheller, M.D., Erie; George H. Stein, M.D., Harrisburg; R. Robert Tyson, M.D., Philadelphia; and Charles M. Worrell, D.O., Harrisburg.

Although the corporation approved the establishment of a Consumer Relations Committee of the Board of Directors, it turned down amendments to increase the number of lay corporation members by twenty-one. The amendment, if adopted, eventually would have increased consumer representation in the corporate body to 50 percent. The Consumer Relations Committee will be composed of five laymen, one physician, and one dentist.

Also approved was the formation of an ad hoc committee to study three areas: home and office visit coverage, physical examination policy, and methods of utilization review employed by Blue Shield.



EXECUTIVE SECRETARIES of the component county medical societies, shown above, met at the end of March in Hershey for a briefing on State Society activities. A similar session is scheduled for May 21 at the Sheraton Motor Inn, Harrisburg. The sessions are designed to keep county medical societies aware of current events affecting medicine. John F. Rineman, executive vice president of the Pennsylvania Medical Society, is shown at the right participating in the session.

Invitation issued

Join medical cooperative!

An invitation to join the Pennsylvania Medical Cooperative is being extended to State Society members in a variety of ways as the Council on Public Service fully implements a membership campaign authorized by the 1973 Session of the House of Delegates. Robert N. Moyers, M.D., council chairman, has announced that over 300 physicians joined the cooperative in the first three weeks of the campaign.

The cooperative will initially handle quality brand-name medical supplies which are used daily in every physician's office. As soon as sufficient funds have been generated, the cooperative expects to expand to include surgical supplies, drugs, biologicals, and office equipment and supplies—areas having the potential for even greater savings. By beginning with high-volume, low warehouse space items and a limited product line, marketing consultants say the plan will break even at a sales volume of $1 million per year—a realistic goal for the initial twelve months of operation.

The opening line will include such items as cotton balls; bandages; gauze sponges; adhesive tape; finger cots; tongue depressors; examination table paper; disposable gowns, gloves, and sheets; paper products (toilet paper, hand towels, facial tissue, EKG paper, cups); disposable needles; alcohol; tetanus toxoid; service towels; combine dressings; germicide; sutures; Lunofax; and Uristick products.

Simply stated, the cooperative will purchase quality brand-name supplies directly from the manufacturers and sell them to the physician member *at cost.* Volume purchasing and elimination of the middleman lowers costs. In addition, the physician's overhead can be cut through the automatic shipment system which streamlines inventory control and reduces personnel time for inventory checking and reordering.

Initial operation will begin as soon as 2,000 members purchase $100 lifetime certificates of membership which entitle the physician to all present and future benefits of the cooperative.

He will also be entitled to vote in the election of a policy-setting board of directors. The plan calls for a ten-member governing board with the majority elected from cooperative members at large and will include at least one member of the Society's Board of Trustees. A membership of 2,000 is needed by September in order for operation to begin by the spring of 1975. If this goal is not attained, the $100 share will be fully refunded. If for any reason a member later needs to withdraw, all or most of that fee will be refunded.

The larger the membership, the greater the leverage in negotiating purchasing agreements and expanding into higher cost items at even greater savings. A 30-50 percent saving is a reasonable expectation initially.

The cooperative is being developed by the Council on Public Service after extensive professional research. It is sponsored by PMS under a mandate from the 1973 House of Delegates.

DAVID A. COPE, M.D., of Reading, above right, represented the State Society and the Pennsylvania Academy of Ophthalmology and Otolaryngology in testimony before the Consumer Protection Committee of the House of Representatives on HB 1827, a measure to regulate hearing aid dealers and salesmen. Dr. Cope told the committee: "The consumer needs more protection than he has enjoyed in the past." Secretary of Health J. Finton Speller, M.D., below right, also testified on the bill.

Society announces Rush awardees

A teacher and transcriber of braille, Mrs. Richard Rollins of Haverford, has been awarded the 1974 state individual Benjamin Rush Award, the Pennsylvania Medical Society's highest layman's health service award which is given in memory of Dr. Benjamin Rush, Philadelphia physician and signer of the Declaration of Independence.

The Children's Aid Society of Clearfield won the group Benjamin Rush Award. Announcement of the winners came from Cyrus B. Slease, M.D., Kittanning, chairman of the PMS Board.

Mrs. Rollins was selected for outstanding volunteer service in training students to become accredited braille instructors. She also conducts adult evening classes, classes at the Emergency Aid headquarters in Philadelphia, and transcribes textbooks for blind students and books for Philadelphia's free library.

The Clearfield Children's Aid Society provides a home for fifteen to twenty children on an interim basis until they can be placed in foster homes or returned to their families.

Throughout the state, county medical societies present awards in recognition of lay voluntary contributors to health care. From these, the state winners are selected and presentations made at the PMS Annual Session in the fall.

Dr. Schnabel president of college of physicians

A Philadelphia internist, Truman G. Schnabel, Jr., M.D., of Philadelphia, was installed as president of the American College of Physicians (ACP) at the organization's annual meeting in April in New York City.

Dr. Schnabel is G. Mahlon Kline Professor of Medicine at the University of Pennsylvania School of Medicine and chief of the University of Pennsylvania Medical Service at the Philadelphia Veterans Administration Hospital. He has served on the National Board of Medical Examiners and on the American Board of Internal Medicine. He succeeds Walter B. Frommeyer, Jr., M.D., Birmingham, Alabama.

Jack D. Meyers, M.D., Pittsburgh, was elected to the ACP Board of Regents.

DR. SCHNABEL

State Society cosponsors venereal disease program

The State Society is cosponsoring a symposium on venereal diseases in Washington, D.C., May 18 at the Shoreham Hotel. Designed primarily for practicing physicians and medical students, it will present the latest scientific and clinical information on the diagnosis and management of gonorrhea, syphilis, and other sexually transmissible diseases.

Sponsors are the American Medical Association and the medical societies of Pennsylvania, Delaware, Maryland, Virginia, West Virginia, and the District of Columbia.

Speakers are members of the faculties of Eastern Virginia Medical School, Harvard Medical School, Baylor University College of Medicine, Boston University School of Medicine, the Mayo Clinic, and New York Medical School, as well as public health officials from Atlanta, Ga. and Washington, D.C.

To register, contact the AMA's Department of Environmental, Public, and Occupational Health, 535 N. Dearborn St., Chicago, Ill. 60610.

Preceptors will train Hershey's MEDEX students

Physicians from eight Pennsylvania counties have agreed to act as preceptors for the third MEDEX Pennsylvania program designed to train physician's assistants at the Milton S. Hershey Medical Center of Pennsylvania State University.

They are: Earl Connors, M.D., Langhorne; Robert Edmiston, M.D., Harrisburg; William Landis, M.D., Columbia; Ira Wagner, M.D., Ephrata; Fernando Araya, Forty Fort; Edward Lottick, M.D., Kingston; Louis Castor, M.D., Philadelphia; Oscar Rothchild, M.D., Philadelphia; Robert Sanford, M.D., Mansfield; Robert Monsour, M.D., Greensburg; and Kenneth Woerthwein, M.D., York.

Those interested in becoming preceptors or students for future classes may contact James Emch, M.D., director of MEDEX Pennsylvania, Department of Family and Community Medicine, Hershey, Pa. 17033.

editorials

Preventing physician suicides

Suicide among physicians is high.

The rate has been judged to be two to three times higher than the population in general. Total deaths of physicians in 1972 as reported in the *Journal of the American Medical Association* numbered 3,187. Of these, death by suicide accounted for fifty-seven. The breakdown by age was as follows:

21-30	3	51-60	14
31-40	9	61-70	10
41-50	16	71-	5

The youngest was twenty-six and the oldest eighty-two. Risk of successful suicide is higher in those forty years of age and older.

Persons who commit suicide are usually mentally disturbed, and symptoms manifest themselves in various ways. Voltaire reminds us that suicide does not "always come from madness. There are said to be occasions when a wise man takes that course: but generally speaking, it is not in an excess of reasonableness that people kill themselves." The most common sign is depression. Heavy drinking, drug abuse, and conflicts with spouses are other preliminary signals.

Physicians show a higher incidence of drug addiction, alcoholism, and psychiatric problems than the general population. The most probable reason is that the physician must be all things to all people at all times. Overworked—and on call twenty-four hours a day, pressured to make the correct diagnosis and prescribe the proper treatment and to keep up with the advances in his field, the physician must necessarily practice medicine under a certain amount of strain. He is also expected to fulfill the roles of husband and father as well as of community leader and to meet a certain number of social engagements.

The method by which physicians take their own lives is not original. In the survey of the fifty-seven suicides listed in *JAMA*, twenty-eight deaths were by firearms. Death by self-administered overdose accounted for fifteen. One hanging, one stabbing, and twelve unspecified round out the list. Firearms are the most widely used method among the general population. Ten of the fifteen drug deaths were by overdose of barbiturates, and three of these combined drugs with alcohol. One might think that drug deaths among physicians would be the method of choice because of the ease of access, and the incidence may in fact be somewhat higher. However, my experience in dealing with diabetics has revealed very few suicides by self-administered overdose of insulin although this method would certainly be the most facile.

The problem with a potential suicide is detection and prevention, if possible. The situation is compounded among physicians by (1) unwillingness to admit illness, (2) tendency to self-medicate, and (3) inability to see themselves in the role of patients. Prevention is a desirable goal, but how to reach the disturbed physician is another question.

David A. Smith, M.D.
Medical Editor

correspondence

Residents' seminar praised

To the editor:

My residents have returned from the Residents' Seminar on Office Management just ecstatic. They thought they were the greatest two days they had ever spent in educational lines. They learned a lot; some of them have twenty to twenty-five pages of notes. They tell me they filled out an evaluation form, but I thought this additional information would be helpful for future planning. Apparently the program was extremely worthwhile.

J. A. Collins, Jr., M.D., Chairman
Department of Internal Medicine
Geisinger Medical Center
Danville

I've got to concede, doctor. The Titleist does seem to be wound tighter than the other balls.

rotogravure

The Institute on Government sponsored by the Pennsylvania Psychiatric Society and The Pennsylvania Medical Society at the end of March achieved its goals of developing communications with government and better understanding of how government works, according to those in attendance. The two and one-half day session was held at the Host Farm in Lancaster and was attended by over 30 legislators and officials of state government and over 70 physicians. The candid snapshots above were taken by Jerry Rothenberger, director of the Pennsylvania Medical Political Action Committee.

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes... yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL
McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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MAY IS NATIONAL HIGH BLOOD PRESSURE MONTH

The Pennsylvania Affiliate of the American Heart Association, its Chapters, the State Department of Health, and the Pennsylvania Medical Society are cooperating with federal and national organizations in a nationwide promotion this month to help make the public more aware of the dangers of high blood pressure and the importance of having blood pressure checked regularly as a preventive measure. The following materials are available from the Heart Association for physicians or for physicians to give to their patients. For a sample copy or information about an item, please check the list below and send to the Pennsylvania Heart Affiliate. To order quantities of these materials, please contact your local heart association.

ITEMS FOR PATIENTS AND PHYSICIANS' OFFICES

( ) *Booklet*-Hypertension: Office Evaluation

( ) *Booklet*-Hypertension: Drug Treatment

( ) *Booklet*-Medical Treatment of Chronic Hypertension

( ) *Booklet*-Recommendations for Human Blood Pressure Determination by Sphygmanometer

( ) *Desk Card*-Outlines of Recommended Antihypertensive Regimens

( ) Information about Modern Pharmacological Management of Systemic Hypertension (slide-casette set)

( ) Information about Hypertensive Mechanisms, Monograph Series (book)

( ) Information about Hypertension Series: Proceedings of Council for High Blood Pressure Research (books)

( ) Information about Medical Treatment of Chronic Hypertension (reprint)

( ) Information about Reprint from Minnesota Symposium: Reducing the Risk of Coronary and Hypertensive Disease (book)

( ) Information about Recurring Bibliography of Hypertension (bi-monthly periodical)

( ) Information about Reports of Inter-Society Commission on Heart Disease:
- ( ) Primary Prevention of Hypertension
- ( ) Resources for the Management of Emergencies in Hypertension
- ( ) Guidelines for the Detection, Diagnosis & Management of Hypertensive Populations

ITEMS FOR PHYSICIANS

( ) *Booklet*-Your Blood Pressure

( ) *Leaflet*-Your High Blood Pressure Prevention Card

( ) *Booklet*-How Can High Blood Pressure Hurt You?

( ) *Booklet*-How You Can Help Your Doctor Treat Your High Blood Pressure (available only on physician prescription)

( ) *Leaflets*-Sodium Restricted Diets (available only on physician prescription):
- ( ) Mild Restriction
- ( ) 1000 Milligrams
- ( ) 500 Milligrams

( ) *Poster*-Perform a Death-defying Act, Have Your Blood Pressure Checked

( ) *Posters*-High Blood Pressure (set of 2)

For sample copy or information about these materials, check this form and send to:

AMERICAN HEART ASSOCIATION, PENNSYLVANIA AFFILIATE

P.O. Box 2435, Harrisburg, Pennsylvania 17105

NAME (Please Print) _____

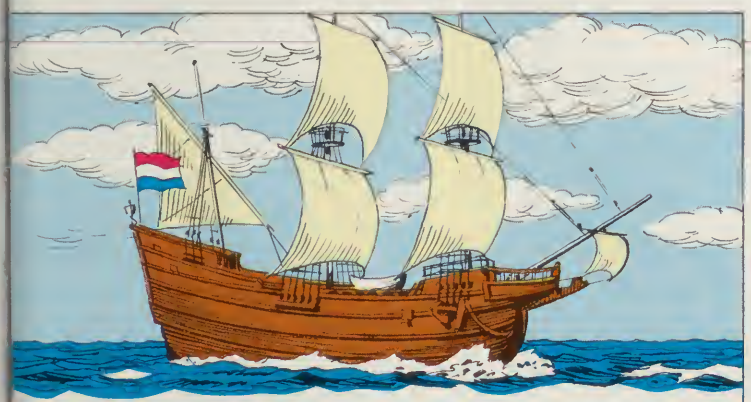
ADDRESS _____ **ZIP** _____

The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies

THE COMMON PRACTICE IN MANY RESTAURANTS, HOSPITALS, AND OTHER INSTITUTIONS INCLUDING OLD PEOPLES' HOMES AND NURSING HOMES OF "HOLDING" COOKED FOODS IN STEAM TABLES BEFORE SERVING RESULTS IN A SIZABLE LOSS OF B AND C VITAMINS.

DURING THE CIVIL WAR 30,714 CASES OF SCURVY WERE REPORTED, AND 383 DEATHS WERE ATTRIBUTED DIRECTLY TO THE DISEASE.

THE AMOUNT OF SUNLIGHT AVAILABLE DURING RIPENING DETERMINES TO A LARGE EXTENT THE FINAL ASCORBIC ACID CONTENT OF TOMATOES. HENCE, A COOL, WET SUMMER PRODUCES WATERY, LESS TASTY FRUIT THAT'S LOWER IN VITAMIN C.



RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula

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Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

A·H·ROBINS A. H. Robins Company, Richmond, Virginia 23220

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

Wellcome

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Research Triangle Park
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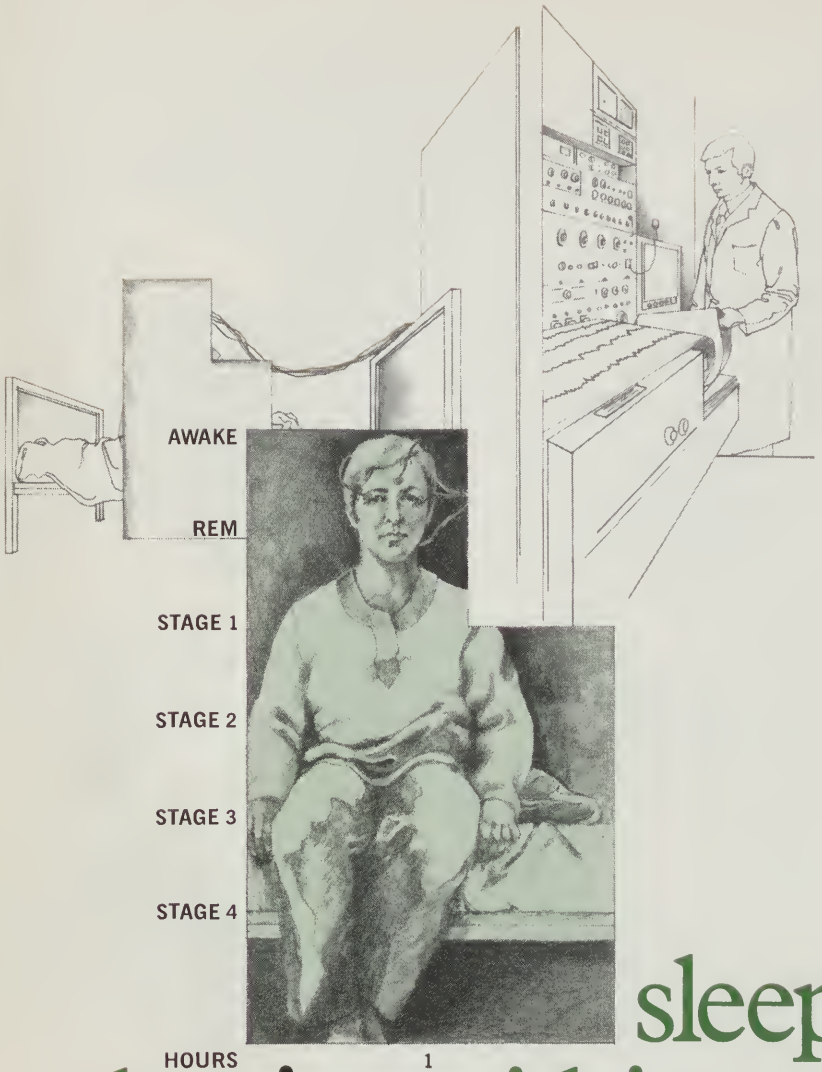


sleep begins within 17 minutes, on average ...

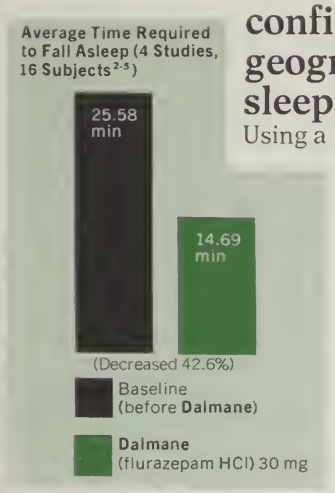
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories [2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

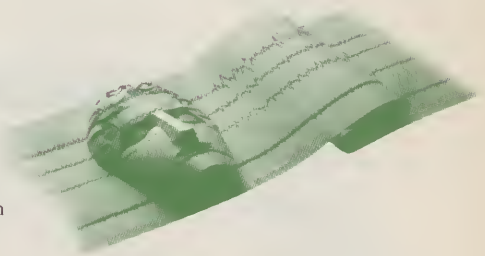
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

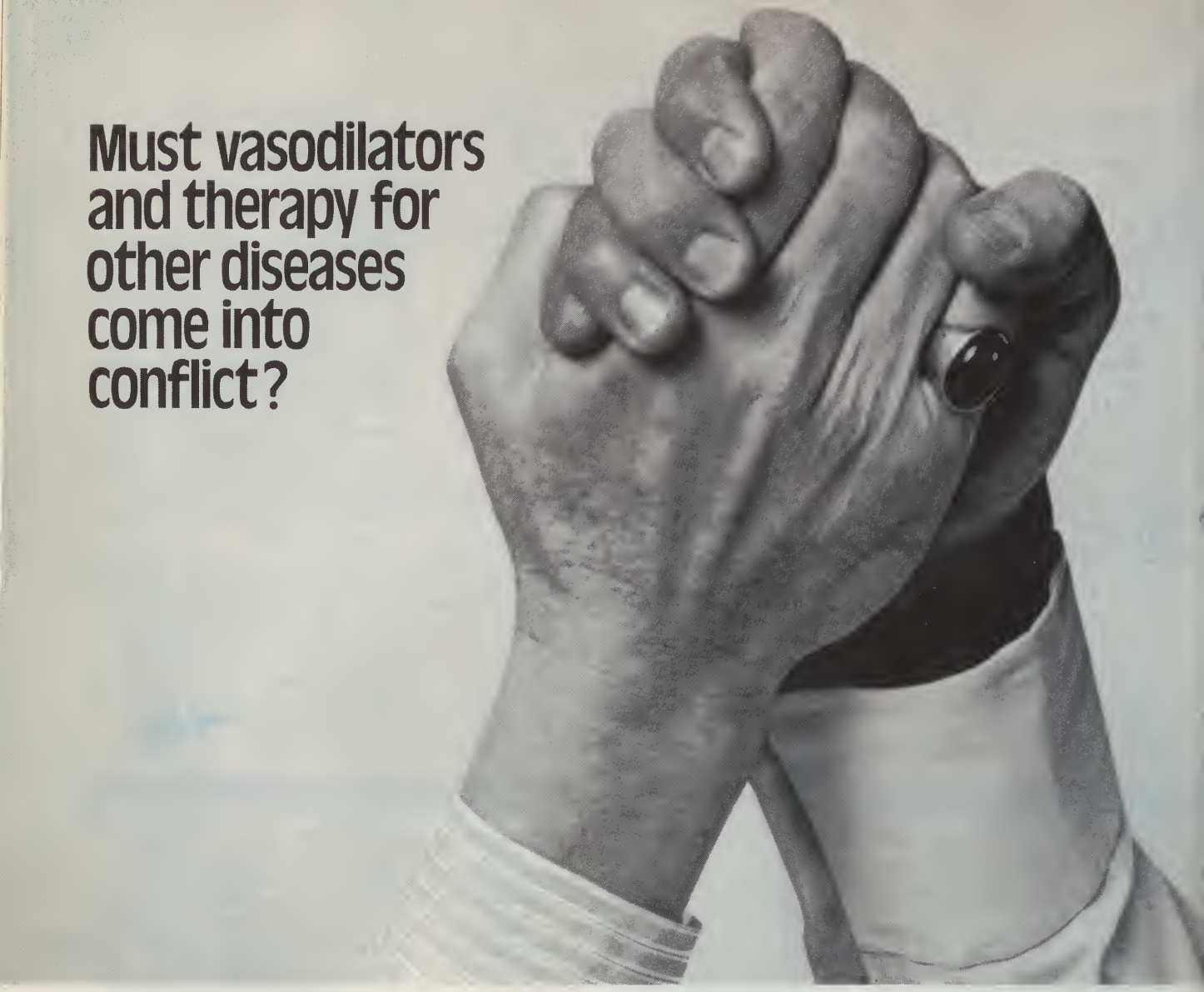
Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25:*134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Narrated by Frank Blair (Commentator with the NBC "Today" Show)

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MS-GP-33

acute gonorrhea*
This patient just received an effective, private, physician-controlled treatment.
It took just one short visit...
Trobicin®
Upjohn
*Urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae
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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

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	SALE	89.	119.	221.	248.	27.	RS	RS	L
PGA Par Ex	List	97.	130.	240.	270.	30.			
	SALE	89.	110.	204.	229.	25.	A	—	L
TONEY PENNA Custom	List	125.	167.	266.	300.	33.			
	SALE	106.	141.	226.	255.	28.	ARS	—	—
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	SALE	77.	103.	147.	166.	18.	ARS	—	L
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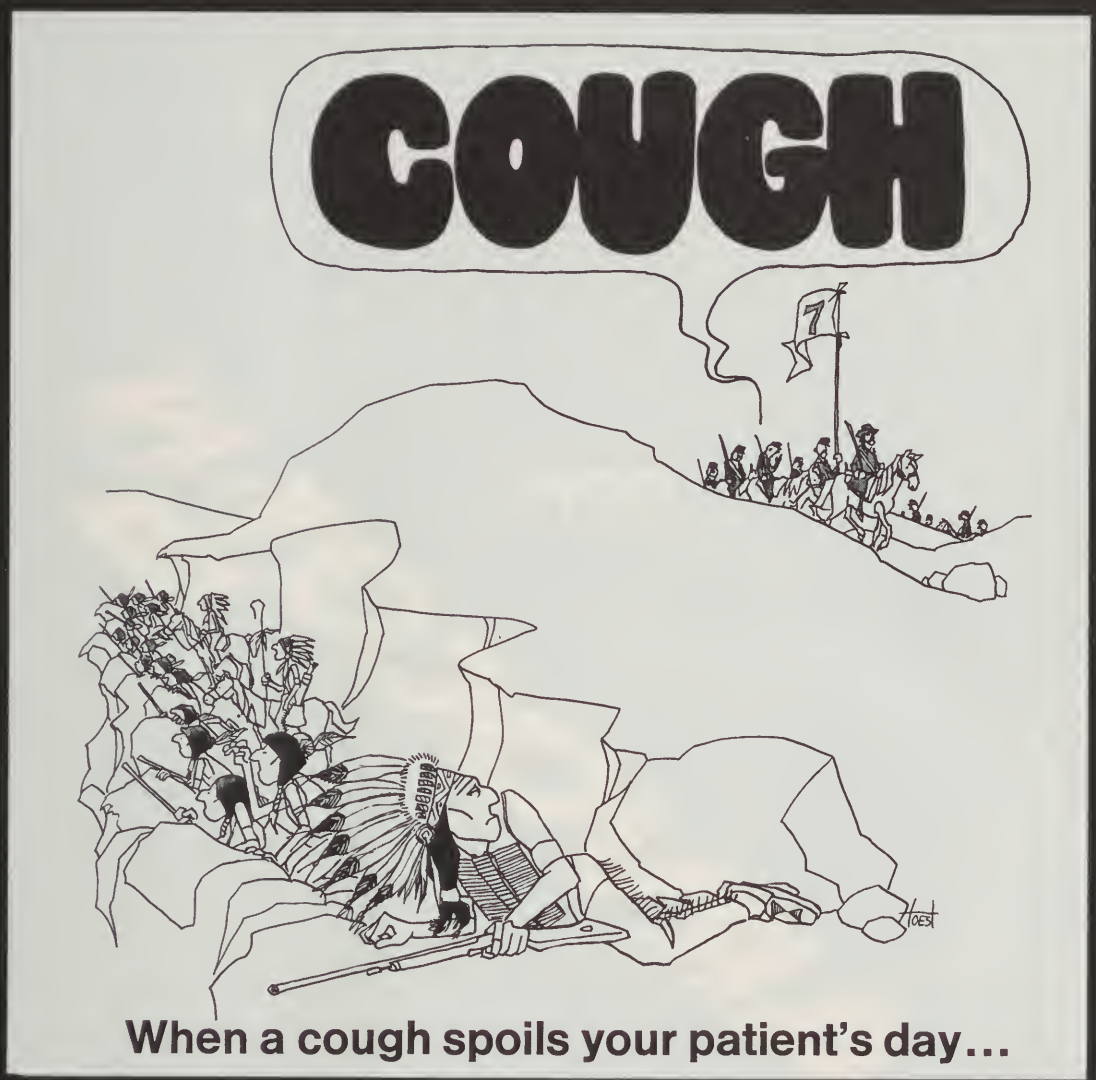

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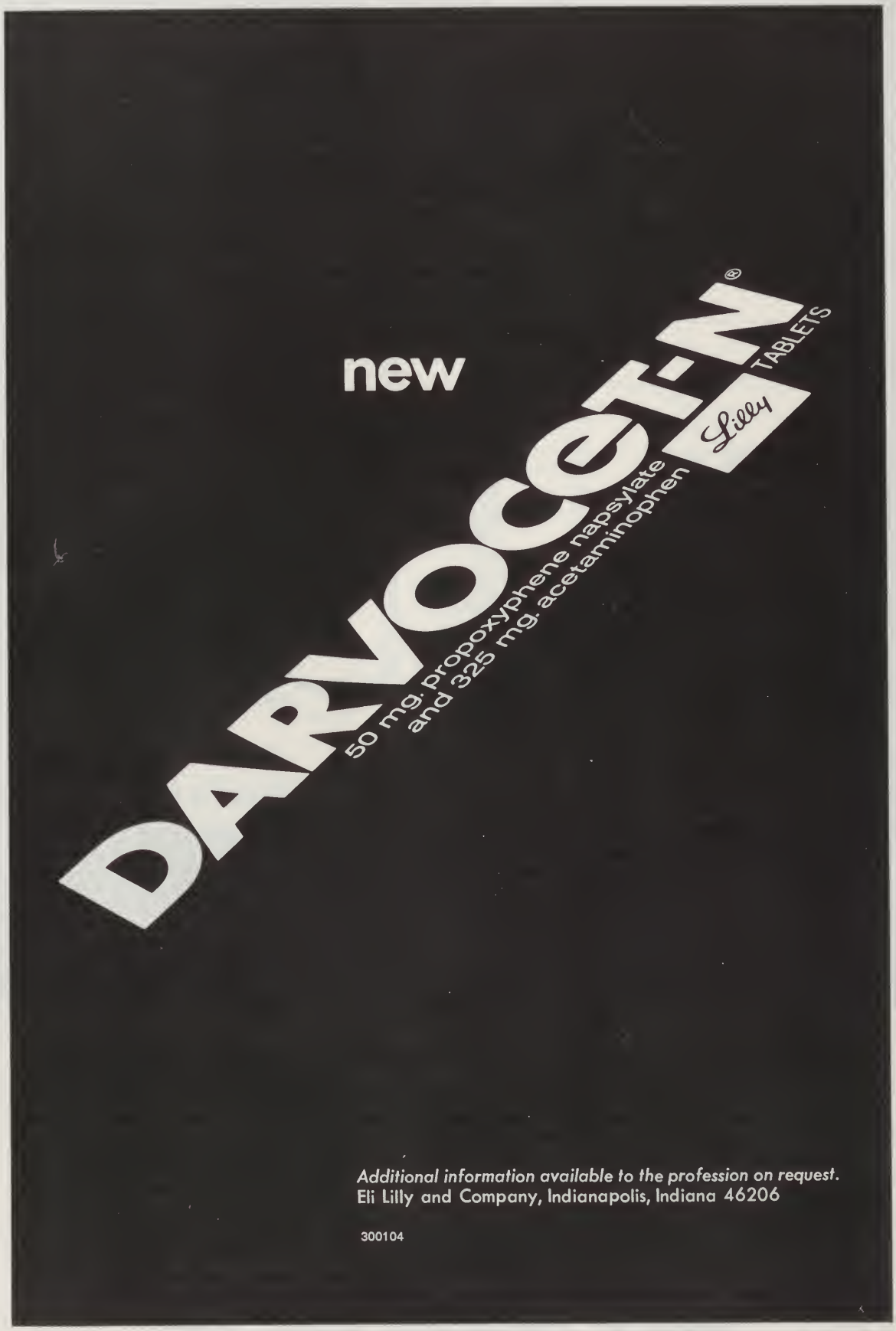
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HMO Act requires package of basic health services

LEIF C. BECK, LL.B.
Bala Cynwyd

This is the second article on the HMO Act of 1973 prepared by the author. The first appeared in the April issue. Regulations implementing the law are being prepared and will be explained as soon as possible following publication.

Last month's article attempted to demonstrate that the "Health Maintenance Organization Act of 1973" is significant to virtually all practicing physicians. It created a three-pronged approach to developing HMOs: first, by providing millions of dollars of seed money; second, by requiring most employers to offer HMO membership in a "dual choice" arrangement; and third, by freeing HMOs from restrictive state laws dealing with regulation and advertising. These opportunities will, I believe, cause HMOs to become desirable alternatives for many patients and will in turn create both threats and opportunities for private practitioners.

Under these circumstances, a basic understanding of what will constitute a federally qualified HMO and how physicians can participate in it become important. These are the subjects of this month's article.

Services Which Must Be Provided

To assure that an HMO offers its patient-members a full range of care, Section 1302 (1) of the Act itself lists a group of services which *must* be offered. This minimum benefit package called the *"basic health services"* includes:

(A) Physician services, which must include consultant and referral arrangements;

(B) Inpatient and outpatient hospital services, the outpatient idea essentially referring to virtually all ambulatory care;

(C) Emergency care;

(D) Short-term (not over twenty visits), outpatient evaluative and "crisis intervention" mental health services;

(E) Medical treatment and referral services for the abuse of or addiction to alcohol and drugs;

(F) Diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) Home health services; and

(H) Preventive health services (which specifically must include voluntary family planning services, infertility services, and both preventive dental care and eye examinations for children up to age twelve).

That is quite extensive. Of particular note is the inclusion of psychiatric, alcohol and drug, home health, family planning, and preventive dental services which are outside the formal scope of even many large group practices presently in existence. As a result, many of us are concerned how the regulations being formulated to implement this Act will deal with these items. What, for instance, will be construed as "crisis intervention" psychiatric help? How much drug and alcohol addiction expertise will the HMO require in-house, as opposed to a mere referral arrangement? What personnel in addition to or instead of the physicians themselves will be authorized to provide "home health services?" The answers to such questions will be important in deciding how to staff an HMO and what its monthly charges will be.

Services Which Also May Be Provided

An HMO is not restricted to those basic health services listed above. The Act continues by listing certain "supplemental health services" which an HMO may offer if it sees fit. It may or may not offer these on prepayment basis, perhaps even making them available for straight fees. Or it might offer the patient-member several alternatives as to payment. As I see it, however, the supplemental services permit an HMO to offer its community as all-inclusive a health care package as it considers appropriate.

These supplemental services may include: (1) facilities for intermediate and long-term care; (2) all vision care; (3) all dental care; (4) all mental health services; (5) long-term physical medicine and rehabilitation services (including physical therapy); and (6) prescription drugs.

The considerable flexibility given an HMO in deciding what, if any, supplemental services to provide and how to finance them is significant. In effect, it allows each HMO to make its own business decisions in creating a package for its buying public—how to price it, market it, organize it, etc. Traditional private practices make few such decisions.

Financing of Services

An HMO is essentially an organization which provides its services to its members on a premium basis—that is, by periodic (usually monthly) payments having no regard to when or what kind of services have actually been provided to the members. This, of course, is the "prepayment" or "capitation" basis which makes the provider essentially like an insurer.

The premium charged for an HMO package must be "community rated," meaning there must be a single price for all persons within the community. This fee

Mr. Beck is president of Management Consulting for Professionals, Inc. of Bala Cynwyd, Pennsylvania.

could not vary according to the health outlook of any single patient or group of patients, thus hopefully assuring that the higher risk groups will not be priced out of participation.

The Act further provides that an HMO may not reject, expel, or refuse to re-enroll any member because of his health status or his requirement for health services. Furthermore, it separately requires an HMO to have an "open enrollment period" of at least thirty days in every twelve months during which it must accept individuals in the order in which they apply. The effect, therefore, is to require broad community coverage by an HMO and to avoid selection of patients for economic or other advantage. This involves an obvious insurance principle of spreading the cost.

Despite this strong principle of insurance-style premium financing, the Act permits a very limited amount of co-payment for specific services. These are specifically called *"nominal payments"* which may not act as a barrier to use of the services. To what extent a separate payment for a certain service might be allowable will depend upon the regulations now being drafted, but it will undoubtedly be kept to a minimum. It may, however, be permitted as a method by which one or several HMOs can form various packages perhaps to offer various employers, thus again increasing its opportunities to "market" medical services more aggressively.

While requiring that an HMO assume full financial risk for the health service to be provided, it also permits the obtaining of reinsurance. This may be done to the extent that the costs for any patient-member's services exceed $5,000 in a year, which would be equivalent to the HMO's taking out major medical insurance on its own members. The organization may similarly take out insurance or make other payment arrangements for those situations in which its patient-members require emergency services by a physician, hospital, or other provider not associated with the HMO. Finally, under the so-called 90/115 percent rule, an HMO may take out reinsurance or make other arrangements to cover situations of aggregate costs which could possibly bankrupt the organization. Under this rule, an HMO may insure for up to 90 percent of the amount by which its costs for a year might exceed 115 percent of its income, a criterion already critized for its restrictiveness. The gist of these reinsurance arrangements is, of course, to give an HMO some flexibility in financing its programs, including inviting the participation of insurance companies in their usual roles of risk-spreading.

Hey, Ed! There's some kinda' practice consultant kook here . . . any idea what he wants?

Who Will Provide Services

Of obvious overriding interest to physicians is the question of how doctors and other health care personnel are expected to work in and for these HMOs. As in the other areas, the Act attempts to provide considerable flexibility from one HMO to the next.

The Act's core definition of an HMO merely requires the organization to provide its services through *"health professionals"* who are members of (a) the staff of the HMO; (b) a "medical group" (or groups); or (c) an "individual practice associate." Thus, there are several important terms requiring careful definition and discussion.

In providing that services be performed by "health professionals," the Act specifically includes physicians, dentists, nurses, podiatrists, optometrists, and others who may be named in the regulations to be issued. Furthermore, if a health service provided by a physician may also be provided under state law by a dentist, optometrist, or podiatrist, an HMO may provide it through any of such allied health personnel. The Committee Reports of Congress considering the Act also expressed the same intent as to licensed psychologists, and one wonders whether other allied health professionals will be permitted. Since HMOs are likely to lead in such areas as use of paraprofessional assistance, I am quite interested in how far the regulations will go in permitting use of nonphysician talent.

Whoever these "health professionals" may be, their working relationship with an HMO is not required to be of any one specific form. Nor does the Act require that they be on a straight salary relationship, for the emphasis is again on *flexibility*—allowing each HMO to decide for itself its economics and its purposes. One arrangement would simply be for the doctor or other professional to be a salaried employee of the HMO; but by specifically including two other alternatives, the legislative philosophy of flexibility is made clear.

A *"medical group"* is defined as a partnership, association, or other grouping of professionals operating essentially as typical medical group practices presently work. It would share the group's income in some prearranged way, share medical records, equipment, and fa-

(Continued on page 40)

M.D.s in the news

Howard F. Warner, M.D., associate professor of medicine at Temple University School of Medicine, is the recipient of the 1973 Russell P. Moses Memorial Award as outstanding teacher in the clinical field at the Temple University medical school.

Roger J. Crossley, M.D., formerly of the British Royal Air Force's Institute of Aviation Medicine, has become associate director in clinical investigation at Smith, Kline and French Laboratories, Philadelphia.

F. Wells Brason, M.D., senior associate pathologist at Harrisburg Hospital, is one of five physicians in the U.S. to be appointed by the College of American Pathologists' board of governors to an energy task force for the conservation of materials and equipment in the nation's pathology laboratories. Shortages of plastic could require extensive changes in laboratory procedures.

Murray Caplan, M.D., Bustleton, accepted an award for the Jefferson Unit of Philadelphia State Hospital for the greatest improvement by a clinical unit at Byberry. The award was presented by **Franklyn R. Clarke, M.D.,** superintendent, to Dr. Caplan, who is clinical director of the unit.

Joseph Gonnella, M.D., associate dean at Jefferson Medical College, Thomas Jefferson University, is acting as a consultant on a new training program for medical school faculties to the World Health Organization in Sydney, Australia.

Domenico Scarano, M.D., Mountaintop, will head an exploratory cancer research program which is being funded by a $102,500 grant to the Luzerne County Medical Society from the National Cancer Institute.

Howard Balin, M.D., has been named professor and chairman of the department of obstetrics and gynecology at Hahnemann Medical College and Hospital, Philadelphia. He is an adjunct staff professor at Drexel University and Temple University and is principal medical scientist at Franklin Institute Research Laboratories.

DR. BALIN

DR. PURCELL

John J. Purcell, Jr., M.D., has been appointed chief resident at Wills Eye Hospital, Philadelphia. He served his internship at Walter Reed General Hospital, Washington, D.C. and was flight surgeon with the U.S. Army.

Children's Hospital of Philadelphia reports that **M. William Schwartz, M.D.,** director of medical services, has been appointed assistant executive secretary of the American Board of Pediatrics in the Philadelphia Office of Research and Development. He is an associate in pediatrics at the University of Pennsylvania School of Medicine. **Festus O. Adebonojo, M.D.,** medical director of Rebound Medical Group, Inc., chaired a special task force at the American Pediatrics Association meeting on childhood lead burden in April. **William J. Mellman, M.D.,** senior physician in the division of metabolism and genetics lectured at the Pennsylvania Association of Blood Banks on human cell hybridization and gene mapping recently.

Peter J. Kyne, M.D., has been appointed head of the department of orthopedics at Western Pennsylvania Hospital, Pittsburgh.

Stanley Gould, M.D., formerly of Trenton, N.J., has become associate director of medical affairs at Smith, Kline and French Laboratories in the pharmaceutical division of SmithKline Corporation. He is a fellow of the American Academy of Pediatrics.

Edwin S. Peters, M.D., and **James C. Ralston, M.D.,** both of Masontown, are the 1974 recipients of the Masontown Exchange Club's Book of Golden Deeds Awards for outstanding service to their community.

Donald A. Dupler, M.D., Bryn Mawr, has been elected to the board of trustees of the American College of Cardiology.

Several new appointments to the medical staff at Geisinger Medical Center have been announced. **L. A. Iannone, M.D.,** has been appointed associate in internal medicine specializing in cardiology. He was formerly director of the coronary care unit and chief of the cardiovascular laboratory at William Beaumont General Hospital in El Paso, Texas. **Robert E. Albertini, M.D.,** is an associate in internal medicine specializing in pulmonary disease. **S. G. Bhatia, M.D.,** former senior staff physician in the department of dermatology at the Henry Ford Hospital, Detroit, Mich., has been named associate in the department of dermatology at Geisinger. **George A. Jansen, M.D.,** formerly associate medical director of Ethicon, Inc., (subsidiary of Johnson and Johnson), Somerville, N.J., has been appointed director of the department of anesthesiology.

New Officers

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Clyde H. Jacobs, M.D., Sunbury, president elect
Benjamin M. Broscius, M.D., Shamokin, vice president
G. R. Wentzel, M.D., Sunbury, secretary
W. W. Christman, M.D., Sunbury, treasurer

Washington County Medical Society

John C. McGinnis, M.D., Washington, president
William H. Kittrell, M.D., McMurray, president elect
Gilbert R. McMaster, M.D., McMurray, vice president
Jon S. Adler, M.D., Washington, secretary-treasurer

m.d.'s in the news

Patrick J. Ferrarro, M.D., Clarks Summit, has been named by the Lackawanna County Commissioners to head a county-wide emergency program to coordinate ambulance and emergency vehicle services and to set up trauma centers in local hospitals.

William C. Beck, M.D., Sayre, president of the Donald Guthrie Research Foundation, has been appointed chairman of the Committee on Operating Room Environment of the American College of Surgeons, Chicago, Ill. Dr. Beck, now retired, was formerly chief of surgery at the Guthrie Clinic and Robert Packer Hospital in Sayre.

Joseph T. Marconis, M.D., Pottsville, has been elected to the Corporate Board of Trustees of Hahnemann Medical College and Hospital. He is president elect of the Pennsylvania Urological Association and a member of the Urology Advisory Committee of the Pennsylvania Medical Society.

The American College of Radiology (ACR) elected **Newton Hornick, M.D.,** Pittsburgh, to a three-year term on the college's Board of Chancellors during its recent annual meeting in New Orleans. Dr. Hornick is senior radiologist at Suburban General Hospital in Bellevue and is affiliated with Dixmont State Hospital, Dixmont. He is a past president of the Pittsburgh Roentgen Society and of the Pennsylvania Radiological Society and is currently secretary-treasurer of the ACR. Pennsylvania physicians who were honored at the meeting by being named fellows of the American College of Radiology are Doctors **Henry J. Woloshin,** Jenkintown, Temple University Health Sciences Center; **Norman J. Winston,** Reading, Jefferson Medical College; **Gene J. Triano,** New Cumberland, Harrisburg Hospital; **Renate L. Soulen,** Narberth, Temple University and St. Christopher's Hospitals, Philadelphia; **Charles H. Sillars,** Gardenville, Abington Memorial Hospital, Abington; **Carl M. Mansfield,** Philadelphia, Thomas Jefferson University Hospital; **Kyuhwan F. Lee,** Narberth, Thomas Jefferson University and Lankenau Hospitals, Philadelphia; **Harford W. Friedman,** Pittsburgh, Montefiore Hospital and the University Health Center, Pittsburgh; **William E. Conrady,** Beaver Falls, Medical Center of Beaver County and Ellwood City Hospital, Ellwood City; **Arnold Chait,** Narberth, University of Pennsylvania Graduate and the VA Hospitals, Philadelphia; **Christopher W. Canino,** Aldan, St. Agnes and Hahnemann Hospitals, Philadelphia; **Robert E. Campbell,** Radnor, Pennsylvania Hospital, Philadelphia; and **David D. Beiler,** Riverside, Geisinger Medical Center, Danville.

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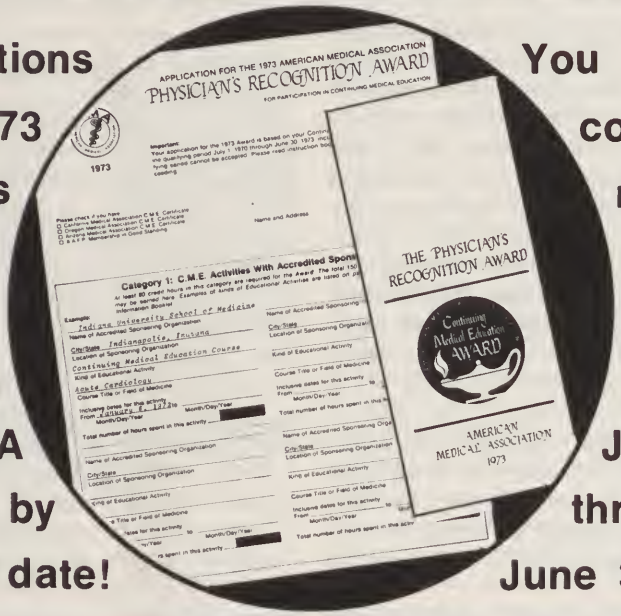

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BEN M. WILLWERTH, M.D. **GARY G. NICHOLAS, M.D.** **WILLIAM E. DeMUTH, M.D.**

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Over 90 percent of abdominal aortic aneurysms are due to atherosclerosis. Nine of ten patients are males. Almost all abdominal aortic aneurysms begin distal to the renal arteries and may or may not involve the aortic bifurcation and iliac arteries. Rupture is the most frequent and serious complication. In 1954, two years following DuBost's report of successful resection of an abdominal aortic aneurysm, DeBakey and Cooley reported on the successful repair of a ruptured abdominal aortic aneurysm.[1, 2] Over the past twenty years the mortality for elective aneurysmectomy has been reduced to less than 5 percent, but mortality for repair of ruptured aneurysms has remained in the range of 40-60 percent.

The mortality associated with ruptured abdominal aortic aneurysm can be reduced by prompt recognition of rupture when it occurs so that appropriate management of the patient can be instituted immediately, thus minimizing the delay between rupture and surgical treatment.

The pathognomonic triad of pain, pulsatile abdominal mass, and hypotension essentially confirms the diagnosis of ruptured abdominal aortic aneurysm. Hemorrhage most frequently occurs into the retroperitoneal space (Fig. 1). The patient may complain of unilateral or bilateral lower abdominal or flank pain. Radiation of the pain into the inguinal area or legs is not uncommon and may be confused with ureteral colic. History of a precipitating event, such as direct abdominal trauma, is very unusual. A pulsatile abdominal mass is almost always detectable; however, small saccular aneurysms may not be palpable in obese patients.

The presence of hypotension is of both diagnostic and prognostic significance. When hypotension is associated with abdominal pain and a pulsatile abdominal mass, the correct diagnosis is almost always ruptured aneurysm. Prognostically, it is clear that hypotension prior to surgery adversely affects survival. One study reported 74 percent survival when hypotension was not present and only 35 percent survival when hypotension was present.[3]

In most instances the diagnosis of ruptured aortic aneurysm can be made without laboratory or radiographic studies. However, anterior-posterior and particularly lateral roentgenograms of the abdomen may be helpful in confirming the diagnosis if calcification is present in the wall of the aneurysm. An intravenous urogram will usually rule out ureteral obstruction and may show displacement of the ureters by the aneurysm or a retroperitoneal hematoma. The cardiorespiratory systems should be examined carefully and the status of the peripheral pulses should be recorded. A preoperative electrocardiogram is indicated if the patient is stable. Arteriography is rarely necessary and generally contraindicated. Multiple examinations of the aneurysm by various physicians should be avoided.

Since crossmatching of blood is relatively time consuming, a blood sample should be sent to the blood bank as soon as the diagnosis is suspected and before other diagnostic or therapeutic measures are performed. Large bore intravenous catheters should be inserted, but it is inadvisable to administer large volumes of fluid initially. Rapid expansion of the intravascular volume will increase blood pressure and may precipitate further hemorrhage. Broad spectrum antibiotics are administered preoperatively. The patient should be taken directly to the operating room and prepared for exploration. The operating room is a much safer place than the emergency room for these patients if sudden hypotension develops.

The surgeon's expertise in vascular techniques undoubtedly plays a role in the recovery of these patients. However, the rapidity with which the *diagnosis* of ruptured abdominal aortic aneurysm is made and the *efficiency* in which preoperative preparation is performed are of equal importance. This responsibility is shared by all physicians, medical or surgical, who are actively involved in emergency patient care.

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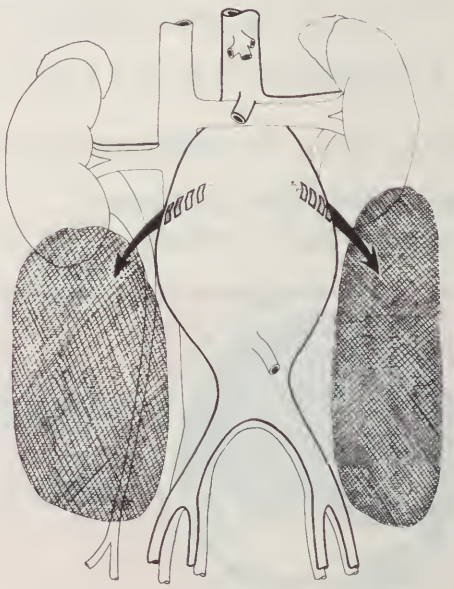

Figure 1

Revenue sharing funds for health programs — why not?

The Society's Council on Education and Science prepared the following article to assist local organizations seeking revenue sharing funds for health programs.

Revenue sharing is the transfer of federal tax monies to states, counties, and local government units. The general revenue sharing law is unusually short and nonspecific. It provides formulas for the disbursement of revenue sharing monies to states and local governments and establishes general categories in which funds may be spent. The formulas allocate the funds on the basis of population, tax efforts, and average income in the community. In some cases, the formulas also include consideration of two additional factors—the percentage of urbanized population and the amount of income tax collected.

Listed below are some illustrative amounts received by Pennsylvania governments during the fourth entitlement period (July 1973 to June 1974.)

TABLE I

State of Pennsylvania	$106,412,929
Allegheny County	13,802,292
Bethel Park Borough	235,392
Bloomsburg Town	156,412
Bedford County	202,658
Everett Borough	20,215
Dauphin County	1,135,945
Harrisburg City	1,290,689
Elk County	268,861
Franklin County	632,212
Chambersburg Borough	194,836
City of Philadelphia	51,078,593
Washington County	1,339,205
Donora Borough	93,927

State and local governments have a great deal of flexibility in the way funds may be used. The use of funds is restricted to:

(1) Ordinary and necessary maintenance and operating expenses for: (a) public safety (including law enforcement, fire protection, and building code enforcement); (b) environmental protection (including sewerage disposal, sanitation, and pollution abatement); (c) public transportation (including transit systems, streets, and roads); (d) recreation; (e) libraries; (f) social services for the poor or aged; (g) financial administration; and (h) health.

(2) Ordinary and necessary capital expenditures authorized by law.

The first revenue sharing payments were made in 1972 when 5.3 billion dollars were distributed. Revenue sharing will continue until at least December 31, 1976, with revenue sharing payments increasing each year until payments reach 6.43 billion in fiscal 1976.

A Harris Survey in the summer of 1972 indicated that 47 percent of the respondents said they would prefer to see the revenue sharing funds used to cut taxes, with 40 percent preferring the improvement and expansion of services. When the respondents were asked to list the areas where revenue sharing money should be spent, 37 percent favored the largest amount going toward aid to education (which is not one of the areas where revenue sharing funds can be used on the local level), 25 percent favored the largest amount going to health, 15 percent favored programs for the poor, 10 percent favored pollution control, and 6, 4, and 3 percent favored housing, mass transportation, and highways respectively.

Local government is following its constituents' wishes by using revenue sharing funds to reduce or hold the line on taxes. However, of the funds spent, only a very small proportion have been spent in the health category. Simultaneously, the federal government is considering ending many of its health programs that directly affect local areas. Many programs which the present administration wished to eliminate have been continued until June 30, 1974, by the Congress. It is unclear whether the Congress will continue programs after that date, but even if they do, the President may impound some or all of the funds.

Revenue sharing will be a fact until at least 1976. It has the potential to provide support for programs and to replace discontinued federal programs to meet previously unmet health needs.

While the need for a particular program is the overriding consideration, some guidelines might be suggested.

(1) In general, "one-shot" programs are preferred to programs where continued funding is needed. A program where initial outlay is relatively high and continued funding minimal is a second choice. In general, local government officials have not funded continuing programs because they are reluctant to commit themselves to long-term programs when they are not sure of long-term support from the federal government. As local government officials become more familiar with revenue sharing and more certain of the continued receipt of specific amounts of revenue sharing funds, the chances for support of continuing programs should increase.

(2) In general, programs should be visible to the general public since public accountability for expenditure of funds is more of a reality on the local level than it is on the national level.

(3) Program support should be sought from only one local government unit. Cooperation between local governments is sometimes difficult to achieve.

(4) In general, county governments will probably be more receptive to health programs than will smaller government units. County government has traditionally had some responsibilities in health, while smaller government units have not.

(5) Health related programs will probably require more background information, community support, and general preparation than programs in the areas where local governments have traditional responsibilities.

Some specific programs are suggested below as examples of areas which would fit into the guidelines suggested above.

Emergency Medical Care—Emergency medical care has been described as the weakest link in our health care system. Possibilities include: purchase of ambulances or improved equipment; purchase of equipment to set up an effective emergency medical services communication network; the establishment of ambulance attendant training courses. In many cases, ambulance attendant training courses are conducted by volunteers, but an initial outlay of funds is required for training aids and equipment.

Hospitals—Hospitals themselves are in the best position to evaluate what improvements can be made to meet the needs of their community. Revenue sharing funds might be a logical source of support.

The Aged Population—It is clear that the needs of the aged are not being met. Support for the upgrading of nursing home facilities and the establishment of residential living quarters for the aged is needed.

Area Health Education Centers—Area Health Education Centers are an attempt on the local level to coordinate and rationalize the training programs for allied medical personnel, nurses and members of the medical profession. Funds from local governments is a logical solution to the fiscal problems involved.

Health Education—Smoking, alcoholism, and obesity have been shown to contribute to ill health. Health education programs begun at the grade school level and continued through adulthood can be extremely important. Examples of programs adaptable to support at the local level are: an information and referral service available via telephone for all residents in the community, improved health education programs in the schools along the guidelines suggested by the Department of Education, and the development and use of doctors' offices and hospital waiting rooms as health education centers for the public.

HMO Act requires package of basic health services

(Continued from page 34)

cilities, use common personnel, and arrange for continuing education of its members. This group must, however, have as its "principal professional activity" (and as a group responsibility) the practice specifically set up for an HMO. The Congressional Committee Reports said this language means the group must have little or no fee-for-service income in order to qualify as a "medical group" working within an HMO, but it will depend upon the forthcoming regulations to make this matter clearer.

Even if a doctor or group does not so limit his or its work to the HMO relationship, however, he or it can still be involved as an "*individual practice association.*" This would essentially be any doctor or group which enters into any arrangement to provide services for compensation, with no apparent limitations on whether that pay be fee-for-service, salary, or otherwise. It thus appears that an HMO or a medical group serving it may in turn arrange for a private practice to render some services to the HMO's patient-members, an arrangement which might be particularly common with respect to some of the less widely used subspecialties.

Of primary importance to physicians, therefore, is that HMOs do not automatically require the exclusion of private practitioners. In fact, the Act leaves as much flexibility as possible in how the doctors will contract for their services. It is reasonable to assume, based on experience to date, that an HMO will need a core group of physicians (probably primary care physicians), either as direct staff employees or as a defined "medical group" to succeed. All additional working services could, however, be provided under whatever payment and arrangements an HMO and a doctor or group should agree upon.

Conclusion

There are, of course, a variety of other provisions concerning the organization and operation of an HMO. For instance, the HMO must have arrangements of quality control stressing "health outcomes" and providing for a peer review process. It must also provide or arrange for continuing education of its health professionals, and it must have procedures for hearing and resolving grievances of its patient-members. Furthermore, it must assure that at least one-third of its policy-making board (perhaps its board of directors) be patient-members and that any "medically underserved populations" in the HMO's service area be equitably represented. While some traditionalists might scoff at these bows to consumerism, I feel they are reasonable expectations of groups intended to offer integrated medical services for the benefit of a community.

Running throughout the Act, and apparent among the hundreds of people studying it at my recent conference, is one central theme. It is simply that health care is business—big enough to merit business and management principles common to all other industries, but too often alien to the physician. The present fragmentation of service among hundreds of thousands of small practices may result in *individual* performances of merit, but there have been too many gaps.

Just as supermarkets have displaced corner grocery stores, so might HMOs offer better arrangements for many people. If the HMOs displace private practices, it will probably be because they have more to offer and/or they offer it better.

The HMO Act of 1973 essentially recognizes that business, management, and marketing skills should be applied to health care. It does not mandate the exclusion of private practice in any way, but it certainly causes doctors to recognize that they too must consider their practices as businessmen. In that respect, the Act provides many choices for doctors and opens up a new world of legal and management considerations for those advisors acquainted with both medical practice and government regulation.

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(Make check payable to American Medical Association.)
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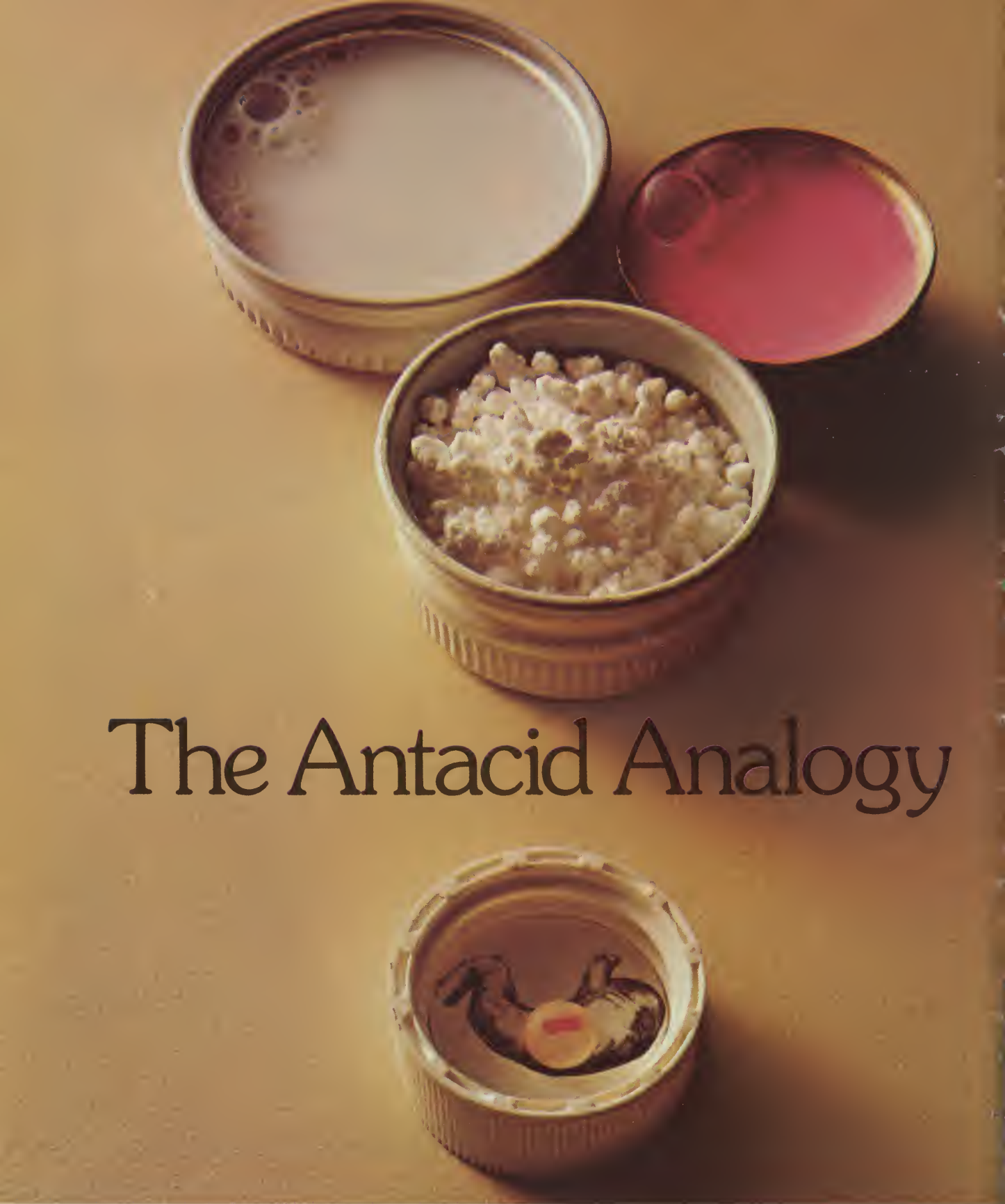

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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VOMITING, REGURGITATION, AND ASPIRATION IN OBSTETRICS

EZZAT ABOULEISH, M.D.
AKE GRENVIK, M.D.
Pittsburgh

The medical editor and his consultants based their decision to publish this comprehensive report because, as the authors state: 'With present advances in the management of cardiac, toxemic, and hemorrhagic patients during pregnancy and labor, aspiration stands out as a prominent cause of maternal mortality and morbidity. It is universally accepted as the most frequent single cause of obstetric death due to anesthesia.'

Aspiration during obstetric anesthesia was first reported by Hall in 1940[1] and clarified by Mendelson in 1946.[2] Since then, anesthesiologists have become more and more aware of this danger. Many articles and reviews have been published dealing with this potentially lethal complication. With present advances in the management of cardiac, toxemic, and hemorrhagic patients during pregnancy and labor, aspiration stands out as a prominent cause of maternal mortality and morbidity. It is universally accepted as the most frequent, single cause of obstetric death due to anesthesia. Merrill and Hingson (1951),[3] on the basis of a review of two and a half million deliveries, estimated that the number of maternal deaths due to aspiration in the United States is about 100 every year. Phillips et al. (1961)[4] estimated that in a community of one million American people, there was one death every year from this cause.

In England, Edwards & Hingson (1956)[5] reviewed one thousand deaths associated with anesthesia and reported more than 50 percent of all obstetric anesthetic mishaps were due to aspiration of vomitus. A subsequent report from England and Wales (Walker, 1960)[6] showed a 40 percent reduction of deaths due to anesthesia; however, aspiration was responsible for 60 percent of maternal anesthetic deaths. In 1966, a follow-up survey showed that of the fourteen avoidable obstetric deaths under anesthesia, twelve were due to aspiration (Maternal Deaths, 1966).[7]

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Anatomy and Physiology

While vomiting is an active process and requires motor activity, regurgitation is a passive process enhanced by motor paralysis. However, both processes may lead to aspiration of gastric content with the same ultimate result.

Vomiting is defined as the forceful expulsion of gastric and intestinal contents through the mouth. It requires adequate stimulation of the

vomiting center in the medulla which, via efferent pathways, sends impulses to the target structures involved in the act of vomiting. Interruption of this reflex arc in any part of the pathway can prevent vomiting.

The stimulus could arise from: gastrointestinal tract, e.g., stimulation of the back of the tongue or throat, overdistension of the stomach or intestinal obstruction; other viscera—such as severe uterine contractions or injury of the uterus; painful conditions—including pain of labor; vestibular stimulation, e.g., motion sickness; drugs, e.g., morphine—which act by stimulating both the vestibular and the chemoreceptor trigger nuclei (Goodman and Gilman, 1970)[8]; and psychological conditions, such as anxiety and apprehension.

The vomiting center (Figure 1) lies deep in the medulla in relation to the nuclei of the vagus, from which it receives impulses and through which it sends messages; the nucleus of tractus solitarius, which controls salivation; the vestibular nucleus, which sends impulses to it; the respiratory center; and the vasomotor center. These are all involved in the act of vomiting.

The chemoreceptor trigger zone (figure 1) is situated dorsal to the vomiting center, in the floor of the fourth ventricle. Chemical stimulation, as by digitalis, or chemical inhibition, as by chlorpromazine, act primarily on this center from which impulses are sent to the vomiting center. On the other hand, nervous stimuli (except motion sickness) act directly on the vomiting center. Destruction of the chemoreceptor trigger zone prevents vomiting due to drugs acting centrally but does not prevent that resulting from gastrointestinal tract irritation (Guyton, 1967).[9]

The efferent pathways of vomiting include the phrenic nerves (C3, 4, and 5), the intercostal nerves (T1 to T12 inclusive), and the cranial nerves—mainly the vagus, glossopharyngeal, and accessory nerves. Immediately preceding vomiting, there is a sensation of nausea with increased salivation, dilatation of the pupils, tachypnea, slow or irregular pulse, hypotension, pallor, and sweating.

The act of vomiting itself involves many pathways, including voluntary and involuntary muscles. To understand these pathways, the mechanism should first be considered. Following a deep breath, the glottis and nasopharynx are closed to prevent vomitus from entering the trachea and the nose. The cricopharyngeal muscle (considered the upper sphincter of the esophagus) is relaxed to allow passage of the vomitus into the pharynx and mouth for expulsion. There is simultaneous descent of the diaphragm, forced expiration, and contraction of the abdominal muscles. This increases the intraabdominal and intrathoracic pressures. The muscles of the stomach and esophagus relax, and the raised intraabdominal pressure is directly transmitted to the stomach, forcing its content into the esophagus, which evacuates its contents into the pharynx and mouth. Emptying of both stomach and esophagus is promoted by peristaltic waves opposite the usual direction. During the act of vomiting, no inspiration takes place, but a deep breath follows; and if the oropharyngeal airway is not clear at that time, vomitus will be aspirated deeply into the bronchi.

Gastroesophageal Junction—Normally, the intraabdominal pressure is higher than the intrathoracic pressure. If there were no mechanism to occlude the esophagus, the stomach contents would readily pass into the esophagus when favored by gravity. This closure mechanism (see figure 2) can possibly be due to a sphincter at gastroesophageal junction. The so-called cardiac sphincter is not an anatomic structure although it often acts in a physiologic manner as a sphincter. It maintains a higher pressure than either the adjacent parts of the stomach or the esophagus can provide. Stimulation of the vagus nerve relaxes the sphincter while stimulation of the sympathetic innervation constricts it. Drugs that affect the autonomic nervous system exert a similar action on the gastroesophageal junction. Thus, atropine increases the tone of the cardiac sphincter and neostigmine relaxes it.

The gastroesophageal angle is usually acute so that the mucosal folds act as a flap valve (Greenan, 1961[10]; Marchand, 1954[11]; Sinclair, 1959[12]). Clinically and experimentally, it has been found that factors which modify this angle change the tendency for reflux. Increasing the gastroesophageal angle, such as in "short esophagus" associated with hiatus hernia, increases the tendency to regurgitate. A rise in intragastric pressure during stomach distension also reduces the angle and predisposes to regurgitation. On the other hand, a simple rise of intraabdominal pressure should act against reflux by potentiating the flap valve closure.

The crura of the diaphragm (mainly the right crus) have been considered to play an important role in preventing regurgitation through contraction (Whillis, 1930).[13] However, destruction or displacement of the crura alone does not cause reflux (Braasch, 1956).[14] Therefore, the current view is that the diaphragm does not play a direct role in preventing regurgitation.

Folds of gastric mucosa may help in closing the gastroesophageal junction. They are responsible for watertight closure. Insertion of a gastric tube renders closure by these mucosal folds inefficient. Overdistension of the stomach or lower end of the esophagus stretches and separates these folds and increases the tendency to regurgitate.

The terminal 2 or 3 cm of the esophagus lie below the diaphragm. Normally this portion is subjected to an outside pressure of +10 cm H_2O, which represents normal intraabdominal pressure. The thoracic portion of the esophagus is exposed to a pressure of -5 cm H_2O, i.e., normal intrathoracic pressure. This creates a pressure difference of 15 cm H_2O against the two portions of the esophagus which keeps it closed, opening only to allow forward flow when the pressure gradient is overcome. Any increase in abdominal

pressure will promote regurgitation by increasing the intragastric pressure, but at the same time, the increase in intraabdominal pressure keeps the terminal portion of the esophagus closed. This is a protective mechanism against reflux in persons with normal gastroesophageal junction. In patients with abnormal gastroesophageal junction or with overdistended stomach, straining can cause reflux (Marchand, 1957).[15] Further, an independent rise of intragastric pressure above the intraabdominal pressure would overcome this valve mechanism (Creamer, 1959).[16]

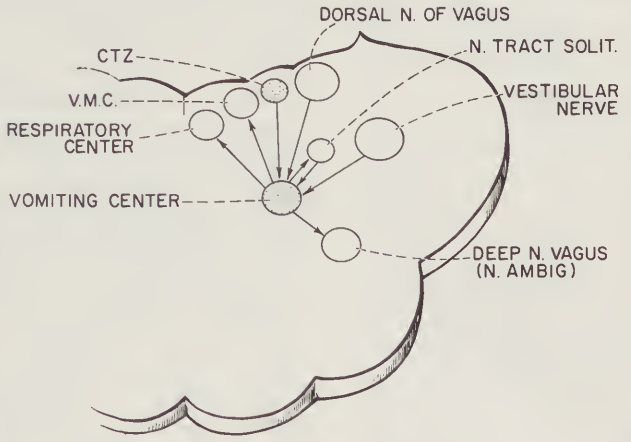
The phrenicoesophageal "ligament," extending from the diaphragm to the terminal part of the esophagus, holds that part in the abdomen and prevents its rise into the thorax. Absence, atrophy, or attenuation of this ligament, e.g. by hiatus herniation, will allow the esophagus to lie totally intrathoracic. Thus, the previous mechanical factor, which depends on the difference in pressure to which the terminal portion of the esophagus is exposed does not exist. A slight increase in intragastric pressure can then cause regurgitation.

. **Upper Esophageal Sphincter**—The cricopharyngeal muscle is a striated muscle and acts as the sphincter at the upper end of the esophagus. It forms the lower part of the inferior constrictor muscle and is innervated, through the vagus, by the cranial part of the accessory nerve. Normally, the esophagus can hold large volumes of fluid (up to 500 ml) without spilling over into the pharynx (Sinclair, 1959[12]; O'Mullane, 1954[17]). Paralysis of the cricopharyngeal muscle by muscle relaxants or deep general anesthesia, or stretching this muscle by insertion of a laryngoscope, can lead to a sudden gush of large quantities of fluid contained in the esophagus.

Regurgitation—During anesthesia, regurgitation is a more frequent and more serious disaster than vomiting. This is because it is a passive process which may not show obvious signs until aspiration results, and it can occur at any time, whether or not a muscle relaxant is used. Vomiting, on the other hand, requires motor activity and may occur only at certain stages during induction or recovery from anesthesia. The normal intragastric pressure is 10-12 cm H_2O (Roe, 1962),[18] and all that is required for regurgitation to occur is a pressure gradient high enough to overcome the sphincter mechanisms at the lower and upper ends of the esophagus (Brown, 1963).[19]

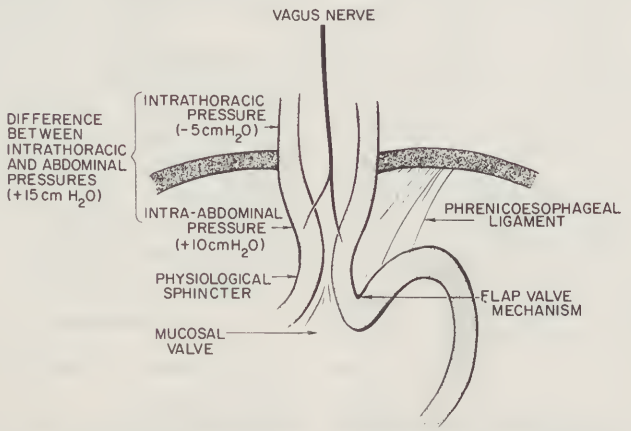
Predisposing Factors During Labor

Many factors and conditions predispose to regurgitation and vomiting in parturient women. Labor may start immediately after a meal. Fluid intake during labor is



CTZ = CHEMORECEPTOR TRIGGER ZONE
V.M.C. = VASOMOTOR CENTER
N. AMBIG = NUCLEUS AMBIGUUS

FIG. 1. CROSS SECTION OF THE MEDULLA OBLONGATA SHOWING VOMITING CENTER AND ITS CONNECTIONS. FOR EXPLANATION SEE TEXT.



PROTECTIVE MECHANISMS AGAINST GASTROESOPHAGEAL REGURGITATION.

FLAP VALVE MECHANISM: THE ACUTE ANGLE BETWEEN THE STOMACH AND ESOPHAGUS.

MUCOSAL VALVE: FOLDS OF GASTRIC MUCOSA HELP IN CLOSING THE GASTROESOPHAGEAL JUNCTION.

PHYSIOLOGICAL SPHINCTER: STIMULATION OF VAGUS NERVE RELAXES THE SPHINCTER. ATROPINE ADMINISTRATION INCREASES ITS TONE.

DIFFERENCE IN PRESSURE ON THE TERMINAL PORTION OF ESOPHAGUS: THIS AMOUNTS TO 15 cm H_2O

PHRENICOESOPHAGEAL LIGAMENT: KEEPS THE TERMINAL PORTION OF THE ESOPHAGUS INTRA-ABDOMINALLY AND MAINTAINS THE ACUTE GASTROESOPHAGEAL ANGLE.

FIG. 2.

not as safe as is thought, because hypertonic fluids can remain in the stomach for long periods (Mortin and Wylie, 1951[20]). Once labor starts, the only safe way of administering fluids is intravenously.

Normal evacuation time for the stomach is 3-4 hours. Pregnancy itself has little or no effect on this evacuation time (LaSalvia, 1950[21]), but labor pain can prolong the time to several hours. Apprehension, exhaustion, hypotension, and certain drugs may also prolong evacuation time. Narcotics such as pethidine (Demerol®*) act by increasing the tone of the antral portion of the stomach and the first part of the duodenum (Goodman and Gilman, 1970).[8] Atropine or scopolamine can prolong evacuation time by inhibiting motor activity of the stomach (Goodman and Gilman, 1970).[8] Further, there may be dryness of the mouth due to inadequate hydration and administration of scopolamine, tranquilizers, and analgesics. This may lead to swallowing of air with gastric distension.

The gravid uterus increases intraabdominal pressure and subsequently rises intragastric pressure. Lithotomy position increases intragastric pressure more than supine position (Wylie, 1963).[22] Direct pressure is usually applied to the abdomen in an effort to aid expulsion of the fetus. Unfortunately, this is not always limited to the fundus of the uterus and may thus increase intragastric pressure.

Acid gastric secretions by the pregnant patient at term do not differ specifically from that of the nonpregnant adult (Hunt, 1958).[23] The volume of gastric content during pregnancy normally varies from a few to over 300 ml (Taylor, 1966).[24] In cases of prolonged labor, pylorospasm may occur due to pain, anxiety, and narcotics; and although food material may be absent, the stomach may still be full of acid secretions, and aspiration can lead to disaster. In a case reported by Adams et al, (1969),[25] the estimated volume of gastric content was 2500 ml in a patient who was in labor for more than twenty-six hours and had received 900 mg of pethidine.

*Winthrop Laboratories

Anesthetic factors can predispose to vomiting and regurgitation by (1) Airway obstruction which enhances regurgitation (Dornhurst et al 1954[26]; O'Mullane, 1954[17]; Stevens, 1964[27]). This can be due to the rise of intragastric pressure by forceful contractions of the diaphragm. (2) Positive Pressure Ventilation before intubation may cause air to enter the esophagus and distend the stomach. This becomes particularly serious in cases of respiratory obstruction where gases are administered by excessive pressure in an attempt to overcome the obstruction. (3) Succinylcholine fasciculations can increase intragastric pressure not by direct action on the gastric musculature but rather by increasing intraabdominal pressure. (4) Stormy induction can lead to bucking and coughing, which also increase intragastric pressure. (5) Each time direct intubation is attempted, the cricopharyngeal sphincter is stretched and made imcompetent. During prolonged intubation attempts, anesthesia may lighten enough or paralysis may fade so that vomiting occurs. (6) Esophageal intubation not only renders the cricopharyngeal sphincter incompetent, but also allows gases to be delivered directly into the stomach (Salem, 1970).[28] These dangers are not much less serious in awake intubation. Therefore, the keystone for management of full stomach, whether the patient is awake or under general anesthesia, is skillful intubation.

Pathology

The results of aspiration of gastric content will vary with (1) aspirated gastric content being solid or liquid; (2) pH of aspirated material; (3) superimposed bacterial infection. Consequently, three classic types of the aspiration syndrome have been described. The first is due to mechanical obstruction, the second to acute chemical inflammation, and the third to bacterial endotoxins; but any combinations of these may also occur.

Mechanical Obstruction of the air passage above the carina by food can cause immediate death. Distal to the carina, lobar or segmental collapse occurs, the extent of which depends on the site of bronchial obstruction. Single or multiple areas of collapse may result. If the patient is supine, as is usually the case at the time of aspiration, the most common site of atelectasis is the apical segment of the right lower lobe. Atelectasis is due to mechanical obstruction by aspirated material as well as to secretions which are produced in response to stimulation of the bronchial mucosa by this material. Depression of ciliary activity and the cough reflex by anesthesia delays removal of the obstructing material. Bacterial growth distal to obstruction may supervene, leading to pneumonitis, lung abscess, bronchiectasis, and empyema.

Acute chemical pneumonitis was first described by Mendelson (1946).[2] He showed experimentally in rabbits that acid vomitus caused irritation of the lungs with resulting bronchospasm and patchy areas of hemorrhage and edema. He injected either 0.1 N hydrochloric acid or unneutralized liquid human gastric content into the trachea of rabbits. At autopsy, both experiments showed congestion and edema throughout the lungs, peribronchial hemorrhage, and exudate with areas of secondary emphysema. The bronchial mucous membrane showed sloughing in scattered areas. When normal saline, distilled water, or neutralized liquid gastric content was injected into the trachea of a rabbit, a brief phase of obstructive respiration ensued, but breathing quickly returned to normal. These lungs only showed scattered areas of atelectasis.

In 1961, Bannister et al,[29] also using rabbits, confirmed the occurrence of aspiration pneumonitis following instillation of hydrochloric acid. They extended the experiment in two ways: (a) by instilling separately in different rabbits the following solutions in the same volume (4ml/kg BW): (a) hydrochloric acid 0.1 N; (b) sodium bicarbonate

0.46N; (c) sodium bicarbonate 0.23 N; (d) sodium lactate 0.1N; (e) sodium hydroxide 0.1 N; (f) normal saline 0.16 N; and (g) calcium gluconate. Both 0.1 N sodium hydroxide and 0.1 N hydrochloric acid produced equally severe lesions. All other solutions, produced either no damage or only slight damage. (2) In another group of rabbits, they instilled hydrochloric acid first, followed by one of the six fluids listed above (b-g). It was found that the lesions were aggravated in all cases, including those receiving 0.9 percent sodium chloride. Bannister, et al. (1961)[29] explained this on the basis that (a) the large volume of fluid served to push the hydrochloric acid deeper into the lungs; (b) mixing of the acid and treatment solution was impossible because of the minute size of the interface; (c) hydrochloric acid probably causes damage within a very short time. Mucklow (1963)[30] added that, even if sodium chloride and hydrochloric acid were completely mixed, the damage would still worsen. This is due to the fact that if equal volumes of hydrochloric acid e.g. of pH 1.6 and sodium chloride are added together, pH only increases to 1.8, but the resultant fluid mixture is twice in volume; since Teabeaut (1952)[31] found that all solutions with a pH less than 2.5 produced lesions of aspiration pneumonitis, the extent of damage would be more widely spread with little change in severity.

Alexander (1968)[32] also using rabbits, instilled either 0.1 N hydrochloric acid, water, or normal saline (4 ml/Kg). The animals were sacrificed 30 minutes later and the lungs were studied macroscopically and microscopically, by light and electron microscopy. He found that the initial lesion from hydrochloric acid, water, or normal saline was similar. There was damage to the alveolar capillary membrane leading to an exudate separating the basement membrane from the capillary endothelium (Figure 3). This separation leads to interference with gaseous exchange across the alveolar-capillary membrane. It explains the early respiratory distress that happens before the appearance of physical signs such as crepitations and frank pulmonary edema. With acid aspiration, the subsequent lesion affected 80 percent of the lung tissue while with water or normal saline this figure was only 30 percent. Further, the degree of damage was more severe with acid aspiration, i.e., there was more congestion, plasma exudate, infiltration by inflammatory cells, necrosis of alveolar epithelial cells, and pulmonary edema.

Thus, aspiration of water or normal saline is not completely innocuous. These findings may add further explanation to the results of Bannister et al. (1961),[29] who found exaggeration of the lesions when instillation of hydrochloric acid was followed by an equal volume of saline. Therefore, these facts should be borne in mind when deciding whether or not to irrigate the tracheo-bronchial tree. In our opinion, irrigation should be used only in the obstructive type of aspiration to loosen food particles, thick mucus, or blood. Irrigation is not recommended in pure chemical pneumonitis. Further, when indicated, only small quantities (5-10 ml) of physiologic saline solution, ideally buffered to normal pH, should be used at a time.

Pneumonitis with acute endotoxin shock occurs when aspirated material from the gastrointestinal tract has a high pH and is bacterially contaminated (Adams et al., 1969),[25] such as in longstanding ileus. Although not as common as the two previously described aspiration syndromes, this syndrome leads to severe bacterial pneumonia and the mortality is even higher than in Mendelson's syndrome.

Clinical Picture

The clinical picture could be that of respiratory obstruction, acute chemical irritation, shock, or a mixture of these in varying degrees. *The initial effect* of any aspirated material is laryngospasm (if the vocal cords are not paralyzed), which, if not relieved, may result in death from hypoxia and cardiac arrest.

In the obstruction type, if the obstruction is distal to the carina or only partial, the clinical picture is that of hypoxia with partial airway obstruction. In the unparalyzed patient, at first there is moderate hyperpnea followed by great respiratory difficulty, particularly during the expiratory phase. This may lead to exhaustion with hypercapnia, and finally apnea may occur. There may also be cyanosis, bronchospasm, and increased resistance to ventilation. During the initial stage, sympathetic activitiy is increased. Thus, there is tachycardia and a rise in arterial pressure, which later falls. X-ray of the chest reveals a rather uniform density of the affected area with mediastinal shift. The heart ultimately fails, the ventricles dilate and may finally fibrillate, leading to death. If the patient survives, secondary infection usually supervenes with signs of consolidation, which may progress into lung abscess, bronchiectasis, or empyema.

In the chemical pneumonitis type (Mendelson's syndrome), although the pathological lesion occurs immediately, the clinical picture may not be noticed for a few hours

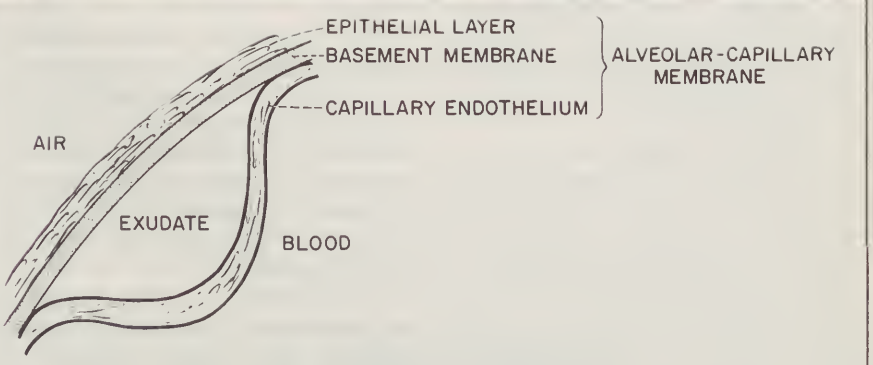


FIG.3 INITIAL DAMAGE IN ASPIRATION SYNDROME

(Mucklow, 1963).[30] This could depend on the quantity of fluid, its pH, response of the patient, and alertness of the anesthesiologist. "A Golden Rule" to follow is: *Aspiration should be suspected until proven otherwise in any emergency case, having or having had general anesthesia with development of cyanosis, tachypnea, tachycardia, and bronchospasm.* In Mendelson's syndrome, no signs of mediastinal shift are seen, but chest x-ray films ususally show irregular mottled densities. Progressive cardiac embarrassment and pulmonary edema may supervene. An important differential diagnosis is acute left ventricular failure. If vomiting or regurgitation precedes the clinical picture, or food material is found in respiratory passages, the diagnosis is easy. In silent aspiration, the diagnosis could be very difficult because both conditions may lead to the same clinical picture since Mendelson's syndrome ultimately also results in pulmonary edema and heart failure. History of previous cardiac disease, and apparent cause for acute left ventricular failure, and progress of the condition can aid in the differentiation. The triphasic sequence of immediate respiratory distress with bronchospasm and cyanosis, followed by partial recovery and a final phase of gradual return of respiratory dysfunction, is characteristic of Mendelson's syndrome.

Pneumonitis with endotoxic shock is more common in surgical than in obstetric patients because it is usually associated with intestinal obstruction. The patient vomits or regurgitates alkaline gastro-intestinal fluid containing large amounts of bacteria. Shock may supervene rapidly. Blood culture as well as bronchial culture shows gram negative organisms similar to those of the intestinal flora.

Pulmonary edema results mainly from injury to the alveolar-capillary membrane. Other contributing factors of pulmonary edema are: (1) mechanical factors—obstruction to the bronchioles and loss of surfactant decrease pulmonary compliance and lead to increased respiratory work, which creates greater negative pressure within the alveoli; (2) pulmonary hypertension from hypoxia and acidosis raises intravascular pressure within the pulmonary capillaries; and (3) onset of acute heart failure from hypoxia, increased vascular resistance, and acidosis, which is both respiratory and metabolic.

Prophylaxis

In obstetrics, every possible precaution should be taken to avoid the occurrence of vomiting or regurgitation. No treatment for aspiration is as effective as prophylactic measures since neglect in taking one single precaution can make the difference between life and death for a previously healthy woman. *The following principles are of extreme importance:*

1. With the exception of elective Cesarean section, every delivery case should be considered as having a full stomach and should be treated accordingly.

2. The possibility of regurgitation and aspiration in vaginal delivery is greater than in Cesarean section because the lithotomy position and application of extra-abdominal pressure to aid fetal delivery increase the intraabdominal pressure. Therefore, vaginal delivery under general anesthesia should be performed with greatest respect. "Give the patient a whiff!" may be the password to a dangerous and potentially fatal complication.

3. General anesthesia for emergency obstetrics should be administered by the most competent person available who is aware of the problems, takes all the necessary precautions, and is capable of performing a rapid, atraumatic intubation.

The authors favor maternity centers in large communities rather than the practice of having obstetric patients dispersed over too many hospitals in the same area. By centralization, obstetric complications, including aspiration, would be minimized because the following can be provided:

1. Twenty-four hour coverage by experienced obstetric anesthesiologists and nurse anesthetists (Cull et al, 1957[33]; Cull, 1960[34]; Bonica, 1967[35]).

2. Better equipment and facilities to prevent complications and to deal with them, if they occur.

3. Better obstetric team, including other physicians and nursing staff, whose management and cooperation will be reflected on the anesthetic mortality and morbidity in obstetrics.

The following precautions should always be considered: (1) The patient, her relatives, and all nursing staff should be instructed that *no food or drinks* be given to the mother once labor begins. Fluid and energy sources must be supplied intravenously. (2) *Avoid General Anesthesia*, if possible. Regional analgesia, when properly administered, gives complete relief of pain without loss of protective reflexes. If no hypotension or hypoxia are allowed with regional anesthesia, the incidence of nausea and vomiting are less than with general anesthesia or narcotics. General anesthesia should be used rarely for vaginal delivery because of the great risk of aspiration. However, a patient under high subarachnoid block can also regurgitate and aspirate while unable to cough because of the associated paralysis of the abdominal muscles. Therefore, the anesthesiologist should be aware of this possibility.

Sometimes regional anesthesia is contraindicated in a patient, e.g., because of anticoagulant therapy, massive hemorrhage, or need for uterine relaxation. In opposition to Crawford (1971),[36] we do not consider pregnancy toxemia as a contraindication to regional analgesia, even for Cesarean section. The relaxation obtained by epidural analgesia will avoid the dangers of interaction between muscle relaxants and magnesium sulfate (Ghoneim, 1970).[37] Nor is forceps trial a contraindication to regional block. In such cases, spinal or epidural analgesia should reach a level suitable for Cesarean section, i.e. T5. In cases of fetal distress, we prefer regional analgesia and 100 percent oxygen administration to the mother over general anesthesia. We feel that induction of spinal anesthesia is quite rapid. However, subarach-

noid block is impractical in cases with prolapsed umbilical cord because the patient must remain supine and in Trendelenburg position with the hand of an assistant in the vagina pushing the head of the fetus up to avoid cord compression.

For vaginal deliveries, the absolute contraindications for subarachnoid or peridural block are very rare. With increased use of the technique, the difficulties and the problems become less common and are dealt with in an efficient and satisfactory way. However, if a contraindication is present, the obstetrician should be asked to use paracervical block combined with pudendal nerve block and local infiltration of the proposed line of episiotomy.

At Magee-Womens Hospital, Pittsburgh, Pennsylvania, 33,804 deliveries were performed during the last five years. Eighty-eight percent of these deliveries took place under anesthesia or analgesia (Table 1), but only 15.2 percent of the patients had general anesthesia, and this figure was as low as 10.4 percent during 1972. These low figures for use of general anesthesia in obstetrics are probably of outstanding importance for the total absence of mortality due to aspiration in this hospital during the last five years (Table II).

TABLE I

Number of Deliveries at Magee-Womens Hospital, Pittsburgh, Pa. During the 5-year period of July, 1967 - June, 1972

Deliveries		33,804
Anesthesia or Analgesia (88%)		29,747
Spinal	75.8%	22,548
General	15.2%	4,522
Epidural	5.4%	1,606
Pudendal	3.6%	1,071
	100.0%	29,747

TABLE II

Causes of Deaths in 33,804 Deliveries in 5 years

Causes of Deaths	Number of Cases
Amniotic fluid embolism	2
Acute pulmonary edema secondary to rheumatic heart disease and active carditis	1
Renal failure, congenital polycystic kidney, and postpartum eclampsia	1
TOTAL	4

Precautions with General Anesthesia—Certain precautions should be taken if the need for general anesthesia arises. Attention to details, skill, and proper judgment are important points that can prevent complications:

Separate Gastrointestinal Tract from Respiratory System. If there is no connection between the two systems, aspiration cannot occur. This can be achieved by sealing one or the other system and connecting it to the outside: (1) The gastroinestinal tract can be sealed by using a cuffed esophageal tube. Although the concept of preventing regurgitation by inflating a cuff at the gastroesophageal junction has appealed to many (Kausch, 1903[38]; Macintosh, 1951,[39] Fisher, 1953[40]; Guiffrida, 1957[41]), its safety is doubtful. The esophagus is a distensible organ. Therefore, it is difficult to maintain a reasonable seal with a cuffed tube (Inkster, 1963[42]; Stevens, 1964[27]). Moreover, if vomiting occurs, the increase in pressure distal to the cuff may distend the esophagus, making a previously satisfactory seal useless or it may dislodge the esophageal tube altogether (Stevens, 1964).[27] (2) The respiratory tract can be sealed by using a cuffed endotracheal tube. There is no doubt that sealing the respiratory tract from the gastrointestinal tract by the use of a cuffed endotracheal tube provides the best protection against aspiration. Therefore, adequate consideration should be given to the possible ways of preventing aspiration during the two critical periods when a cuffed endotracheal tube is not in place. The first period is from the start of induction to the inflation of the endotracheal tube cuff. Vomiting and regurgitation during induction of anesthesia have been long recognized as one of the most important causes of mortality and morbidity in patients submitted to general anesthesia. Although there is general agreement to its dangers, the method of preference varies. None of the three methods available (awake intubation; inhalation induction; intravenous "crash" induction) is foolproof and none is suitable for an inexperienced or unskilled anesthesiologist or nurse anesthetist. The second period is from the removal of the endotracheal tube to the recovery of all protective reflexes. The endotracheal tube should be left with the cuff inflated in the trachea as long as it is tolerated and under no circumstances removed before return of protective reflexes.

Awake intubation—With gentleness, experience, and proper explanation, the passage of a tube in an awake patient can be made tolerable. Intravenous diazepam, 5 mg, may help to relax and sedate the patient. Diazepam, in such a dose, is safe to use in obstetric anesthesia (Flowers, 1969).[43] The patient is carefully positioned with the neck flexed and the head extended at the atlanto-occipital joint. The patient is asked to open her mouth at which time the tongue, pharynx and palate are sprayed with 4 percent lidocaine. The patient is told that a light will be used in her throat to position a tube and the laryngoscope is slowly advanced. Additional lidocaine may be used to spray the valleculae and the anterior surface of the epiglottis, but not the larynx. The patient is asked to relax and breathe deeply. The tube is inserted when the cords are widely open. Once the tube is in place, the cuff is inflated and an oropharyngeal airway inserted in order to avoid

biting on the tube when the laryngoscope is removed. Anesthesia is induced rapidly by intravenous route if the patient's condition permits. In case of difficulty, nasopharyngeal spray is used followed by blind nasal intubation. In experienced hands, blind nasal intubation has a high rate of success with very little discomfort to the patient. Carbon dioxide administration or doxapram intravenously (1mg/Kg) before nasal intubation increases the success rate since the vocal cords open widely during hyperventilation. Recently the use of the fiberoptic laryngoscope in difficult cases has proven advantageous. (Taylor and Towey: 1972,[44] and Stiles, et al. 1972[45]).

Theoretically, awake intubation would be the safest method because the respiratory tract is sealed from the gastrointestinal tract before loss of consciousness. Moreover, the patient is spontaneously breathing, and therefore adequate time is available. However, awake intubation has several disadvantages. It does not always eliminate the danger of regurgitation and aspiration. Fluid may have accumulated in the esophagus and stretching of the cricopharyngeal muscle by the laryngoscope will make that sphincter incompetent so that a sudden gush of gastric fluid may enter the trachea. This can be provoked by inadequate topical anesthesia of the oropharynx, at which time the insertion of the laryngoscope may stimulate the vomiting reflex. Local anesthetic so liberally applied as to include the larynx is also dangerous, because if regurgitation occurs, no protective reflex is present to prevent aspiration. Further, the experience can be unpleasant for the patient, especially if technical difficulty is encountered. The technique is easy in edentulous and frail patients, but in young healthy individuals with a full set of teeth as in the majority of obstetric patients, the technique is relatively difficult and requires much skill since relaxation is usually inadequate.

Inhalation induction—After the usual check of the anesthesia machine and other equipment, including suction equipment, anesthesia is induced while the patient lies horizontally supine. High flow of gases is used to help rapid elimination of nitrogen. Carbon dioxide absorber may be turned off at the start and 5 percent carbon dioxide added to inhaled gases to prevent breathholding, an essential preliminary to active vomiting (Inkster, 1963).[42]

Hyperventilation, as well as the acceptance of rapidly increasing concentrations of potent inhalation anesthetics will speed the induction period (Hamelberg, 1964).[46] Slow induction can initiate vomiting because the patient may remain in the excitement stage too long, and central stimulation of vomiting may occur. With the original technic, ether or cyclopropane were used (Inkster, 1963[42]; Bourne, 1962[47]). Later on, other anesthetics were employed including methoxyflurane (Ivankovic, 1970).[48] In lambs, Motoyama et al (1967)[49] found that hypercapnia had no adverse effect on the fetus. Ivankovic et al. (1970)[48] confirmed this finding in human beings. They also found that umbilical vein oxygen tension and Apgar scores were higher and the time to sustain respiration was shorter in the hypercapnic group than in the normocapnic group. This was attributed to the possibility of stimulation of the respiratory centers of the neonates by hypercapnia.

The main advantages of this technic is that apnea resulting from the use of relaxants is avoided. Therefore, there is adequate time for intubation in difficult cases. Also, the use of blind nasal intubation is accompanied by a higher success rate as a result of hypercapnia and presence of muscle tone of the pharynx. If vomiting or regurgitation does occur, the protective reflexes are still active. Further, the presence of spontaneous respiration eliminates the need for positive pressure ventilation prior to intubation, thus preventing the rise of intragastric pressure from pushing gases into the stomach.

With the described technique, the induction period is shortened during inhalation induction, but it is still much longer than with the intravenous method. The longer the period of unconsciousness before intubation, the higher the risk of vomiting and regurgitation. Moreover, the longer the period of administration of general anesthesia prior to delivery, the more depressed the baby will be (Marx, 1970).[50] Also, relaxation is not as ideal as with the use of muscle relaxants, and premature attempts at intubation before adequate level of anesthesia is reached can lead to disaster. Inadequate relaxation makes laryngoscopy difficult and prolonged, anesthesia level becomes lighter, and the vomiting reflex is stimulated by the laryngoscope.

Intravenous "crash" induction. This is our method of choice because: induction is rapid (the time interval between loss of consciousness and sealing of the trachea is very short), fetal depression is minimal, and the technic is pleasant to the mother. However, the mother is paralyzed, and oxygenation depends on preliminary breathing of oxygen. Thus, the time allowed for intubation is limited. Further, if attempt at intubation is prolonged, the patient may recover partially from the state of paralysis and active vomiting may occur. Therefore, if an intubation problem is anticipated, such as in a patient with a markedly receding jaw, it is best to resort to other methods of induction or to avoid general anesthesia altogether.

The usual time for injection of succinylcholine is immediately after sleep induction by thiopentone. To further shorten the induction period, injection of mixtures of thiopentone and succinylcholine have been advocated (Khawaja, 1971),[51] but there is no guarantee that all patients will become unconscious before the action of succinylcholine takes place. Some were still conscious and were frightened by the inability to breathe (Alexander, 1971.)[52]

Reduce Intragastric Pressure. For those patients in whom a full stomach is suspected, it has been assumed that the danger of aspiration could be avoided by emptying the stomach prior to induction. Howev-

er, completely emptying the stomach is usually not possible. The aim is to evacuate as much as possible in order to reduce intragastric pressure far *below the critical pressure at which reflux occurs*. This critical level varies between 15 and 70 cm H_2O with an average of 30 cm H_2O (Greenan, 1961[10]; Clark, 1962[53]). Lowering of intragastric pressure prior to anesthesia can be achieved by inducing vomiting or introducing a stomach tube.

Induction of vomiting can be evoked by stimulating the back of the tongue or the pharyngeal wall. Some are able to do this themselves or it can be done with a catheter. Certain drugs stimulate the vomiting center via the chemoreceptor trigger zone. The most common emetic drug is apomorphine (Holmes, 1956[54]; White, 1959[55]; Crawford, 1971[36]). However, this drug is not always effective, and complete emptying of the stomach is not guaranteed. It is also unpleasant to the patient, and such drugs may produce cardiovascular collapse.

Insertion of a gastric tube is the most common method for evacuation of the stomach (Edwards, 1956[5]; Bonica[35]; Salem[28]; Salem, 1971[56]). Again, complete evacuation should not be expected. Even a wide-bore stomach tube is not necessarily able to remove all large food particles, but at least intragastric pressure is lowered and can be reduced further by suction just prior to induction. Moreover, by leaving the distal end of the tube open, it can act as a safety valve for any increase in intragastric pressure during induction. Therefore, the method of choice for evacuating the stomach is to use a nasogastric tube. The question is whether it should be inserted prior to anesthesia in every obstetric patient. This is more ideal but difficult to practice for several reasons, e.g., to a patient in labor, the need for anesthesia may be so urgent that no time can be spared for emptying of the stomach.

Although we consider all mothers in labor as having a full stomach and being a potential candidate for vomiting or regurgitation, we divide them into two groups in regard to the need for a stomach tube. (1) *The stomach is certain to contain food* when labor has started within six hours of food intake. In this group, if time allows, the widest possible stomach tube is inserted prior to anesthesia. To make the patient relatively comfortable and to minimize trauma, 4 percent lidocaine is administered as nasal drops a few minutes before insertion of the tube. The tube is then well lubricated with lidocaine gel. Positive evidence that the tube is in the stomach is confirmed by aspiration of gastric fluid or by injection of air into the tube while auscultating the left hypochondriac region (Inkster, 1963).[42] Do not inject fluid into the stomach tube to confirm its position because in a moribund patient the tube could be in the tracheobronchial tree (Inkster, 1963).[42] Apply gentle suction since excessive suction can cause occlusion of the tube. (2) *The stomach is likely to contain food* when labor has started more than six hours after food intake. In this group, no stomach tube is inserted before induction, but all other precautions for "crash" induction are adhered to.

When the patient is under anesthesia, insertion of a nasogastric tube may be more difficult. Therefore, the authors always prefer to insert it before induction. If insertion of a nasogastric tube is required in an anesthetized, intubated patient, gentle lifting of the larynx can allow the tube to pass easily through the upper part of the esophagus (Stept and Safar, 1970).[57] One method is to insert the nasogastric tube through the nose and pull the distal end through the mouth for a distance of about 18 inches. Insert a noncuffed Magill endotracheal tube, with a side slit, through the mouth into the esophagus. When the Magill tube is in the esophagus, pass the nasogastric tube down through it into the stomach. The slit Magill tube is then removed from the nasogastric tube. When the nasogastric tube is in the stomach, it is fixed to the nose and side of the face in such a way that it does not cause pressure on the external nares.

Use of Antacids. Gastric aspirate pH is an important factor in determining the severity of the chemical irritation. In a study of eighteen patients with aspiration pneumonitis, by Lewis et al (1971),[58] all patients with gastric aspirate of pH less than 1.75 died, whereas only one, probably unrelated death, occurred when aspirate pH was greater than 2.4. Therefore, administration of antacids is considered an important prophylactic measure. Taylor and Pryse-Davis (1966)[24] introduced prophylactic ingestion of magnesium trisilicate mixture (BPC) to maintain acidity of the gastric contents above pH 2.5 during obstetric labor. Williams and Crawford (1971)[59] recommend the administration of 15 ml of magnesium trisilicate mixture orally every two hours to maintain the gastric content pH above 3.0. Thus presumably, if such contents are aspirated, the Mendelson syndrom will not develop. The composition of the recommended mixture is as follows: magnesium carbonate, 5.0 g; magnesium trisilicate, 5.0 g; sodium bicarbonate, 5.0 g; and peppermint water to 100 ml. Repeated administration of this mixture can increase the blood level of magnesium in the mother, but such an increase is highly unlikely to be detrimental to either mother or infant (Aviet and Crawford, 1971).[60] Unfortunately, it seems that preoperative alkali therapy gives a false sense of security and cannot be relied upon to prevent development of pneumonitis should aspiration occur, since Adams et al (1969) reported a case of massive severe pneumonitis in a patient who received magnesium trisilicate mixture before induction of anesthesia.

Prevention of Succinylcholine Fasciculations—Succinylcholine fasciculations raise intragastric pressure (Anderson, 1962[61]; Roe, 1962[18]; Spence, 1967[62]; Miller, 1969.[63]) This rise in pressure is more significant in adults than in children (Salem, 1971).[56] It can reach a pressure as high as 50 cm H_2O and overcome the sphincter mechanism at the gastroesophageal junction. However, these fasciculations can be prevented by prior administration of

a small dose of a nondepolarizing muscle relaxant, e.g., 3 mg of d-tubo-curarine. To obtain adequate relaxation, the dose of succinylcholine must be increased from 1 to 1.5 mg/kg when a dose of nondepolarizing muscle relaxant has been used (Cullen, 1971).[64]

Position During Induction—In patients who are fasting and submitted to routine anesthesia and surgery, intragastric pressure is most often below 10 cm H_2O, although figures of 15 - 16 cm H_2O are not infrequent (O'Mullane, 1954[17]; Marchand, 1957[15]; Roe, 1962[18].) In patients with abdominal distension, such as with a gravid uterus, O'Mullane measured pressures of 15 - 18 cm H_2O. Placing a patient in a 40° head-up tilt will rise the larynx 19 cm above the gastroesophageal junction (Snow, 1959).[65] In this position it is assumed that gastric contents will not reach the laryngeal level, even if forced into the esophagus (Snow, 1959[65]; Hodges, 1959,[66]) but this is not always the case. Regurgitation may still occur in this position (Bourne, 1962[47]; Stept and Safar, 1970.[57]) The results of regurgitation become very serious in such a paralyzed patient since aspiration becomes inevitable and even fatal aspiration has been recorded in such a head-up position (Mucklow and Larard, 1963).[30] Postural hypotension during induction is also likely to occur, expecially in hypovolemic patients. To avoid this postural hypotension, Stept and Safar (1970)[57] recommend the V-position with the trunk elevated 30° and the feet raised.

The use of thiopentone muscle relaxant induction with head-down tilt was recommended by Mucklow and Larard (1963)[30] on the assumption that if regurgitation does occur, gravity will prevent aspiration. It also avoids cardiovascular collapse that can occur in the head-up position. However, the best way to avoid aspiration is to prevent regurgitation in the first place, and this position definitely favors such a complication.

Another method is to place the patient in lateral position with a slight head-down tilt, and induce anesthetics. Hyperventilation, with CO_2 admixture, may be used to speed up induction and depress the vomiting mechanism. But the disadvantages of this technic are that regurgitation can still take place, particularly if respiratory obstruction occurs and conditions for intubation are not optimal.

Head-up, head-down, and lateral positions, although each offering some benefit, all have disadvantages which outweigh the advantages. Therefore, we recommend the horizontal supine position with which the anesthesiologist is most familiar. If other precautions are taken and rapid induction with skillful intubation is performed, the risk of aspiration should be very small. A pillow under the head facilitates intubation, since it places the head and neck in optimal position to visualize the larynx. Neglect of this often leads to problems and no chances should be taken in a patient with a full stomach.

Cricoid Pressure—The use of cricoid pressure to prevent regurgitation in the unconscious and paralyzed patient was first recommended by Sellick (1961).[67] In the Sellick maneuver, the cricoid cartilage is pressed against the body of the sixth cervical vertebra, thus occluding the esophagus. It also facilitates intubation by bringing the larynx into view. Postmortem studies were done to determine quantitatively the efficiency of cricoid pressure in preventing regurgitation of gastric contents (Fanning, 1970[68]; Salem, 1971.[56]) Cricoid compression was found to provide protection against regurgitation until intra-esophageal pressure reaches 50-100 cm H_2O. The presence of a nasogastric tube was thought to diminish the effectiveness of this method in occluding the esophageal lumen (Inkster, 1963[42]; Weaver, 1964.[69]) But, Salem (1971)[56] found, at least in children, that the nasogastric tube does not interfere with the efficiency of cricoid pressure in preventing regurgitation. A patent nasogastric tube is a safety valve against excessive rise of intragastric pressure and subsequent regurgitation. Thus, the presence of the nasogastric tube and cricoid pressure are synergistic rather than antagonistic.

The disadvantages of the Sellick maneuver are the theoretically possible rupture of the esophagus if vomiting occurs while cricoid pressure is maintained (Sellick, 1961),[67] and possible trauma to the larynx if the pressure applied is too excessive. Therefore, only a trained assistant who is aware of these dangers should be allowed to apply cricoid pressure. Surface marking of the patient's cricoid could be outlined before induction (Crawford, 1971).[36]

Technic of Intravenous—"Crash" Induction—This technic is used for vaginal delivery or Cesarean section when general anesthesia is indicated. If possible, intravenous infusion should be started outside the operating room using a plastic cannula that is well-fixed to the skin to ensure against its dislodgement at the critical moment. Sometimes this complication occurs, and before another vein is cannulated the patient vomits. A blood pressure cuff and a stethoscope are applied. If there is indication to insert a nasogastric tube, do not hesitate to do so. If a nasogastric tube is present, let it remain in situ after making certin that it is well-fixed and patent. Make sure at least three cuffed oral tubes of different sizes and one nasal tube are available. Check the cuffs and connect a syringe for air injection to the cuff of the most suitable tube. The tubes should be well-lubricated and have a straight connector attached. If a stylet is used, it should be well-lubricated and easy to remove and reinsert. Test the laryngoscope and have an extra one available in case the light fails. Use the type of laryngoscope with which you are familiar. Have an airway or a bite block ready. There should be extra full cylinders of oxygen and nitrous oxide on the machine in addition to those in use. Do not be misled by the attached label. Check the cylinders yourself. There should be a powerful suction available. Have a tonsil suction tip attached and several rubber or plastic sterile suction tubes available. Check the suction for leakage. Check the drugs you

may need for anesthesia and for resuscitation if aspiration should occur.

The delivery or operating table is kept horizontal but should allow tilting if vomiting occurs. Put a pillow under the patient's head for comfort and proper positioning during laryngoscopy. Allow the patient to breathe 100 percent oxygen at a high flow rate with a well-fitting mask. The patient should breathe oxygen spontaneously until paralysis is complete. Do not use positive pressure ventilation. Inject 3 mg curare intravenously followed by 0.6 mg atropine. Usually, the patient does not feel any effect from this dose of curare but might feel some palpitation due to the atropine. During the next three minutes: apply ECG electrodes or a precordial stethoscope; continue oxygen administration and apply gentle suction to the stomach tube, if present, to reduce intragastric pressure. Attach a plastic bag to the nasogastric tube and allow the end to hang down below the level of the stomach. Gravity will facilitate drainage, and no excessive pressure builds up. After the three minutes interval, start induction by intravenous injection of a predetermined dose of thiobarbiturate directly into the vein or into the intravenous tubing as close to the vein as possible. The usual dose is 4 mg/kg (Kosaka et al, 1969),[70] which is reduced in a patient who is hypovolemic or critically ill. Ketamine might be administered in such cases (Chodoff and Stella, 1966[71]; Moore et al, 1971.[72]) Tilt the head gently backwards and ask the assistant to apply and maintain firm cricoid pressure until the cuff of the endotracheal tube is inflated. When the eyelash reflex disappears (indicating loss of consciousness) inject succinylcholine in one dose. The dose is 1.5 mg/kg injected directly into the patient's vein or in the intravenous tubing as close to the patient's vein as possible. Continue oxygen administration. When respiration ceases, remove the mask quickly and perform intubation. Quick, gentle intubation is the key to success. Never try to intubate a partially paralyzed patient. Inflate the cuff, connect the tube to the anesthesia machine, squeeze the bag to make sure there is no leakage around the cuff, then ask the assistant to release the cricoid pressure.

In cases of vaginal delivery, lithotomy position is instituted after intubation. Maintain anesthesia with nitrous oxide, oxygen, and succinylcholine drip of 0.1 percent concentration. To avoid bacterial contamination, a small bottle of 250 ml of succinylcholine mixture, which is disposed of at the end of the procedure, is preferred to a larger bottle used for more than one patient. The rate of succinylcholine drip is regulated by the aid of a peripheral nerve stimulator or by allowing slight respiratory movements. If complete muscular paralysis is maintained throughout the procedure, resumption of adequate ventilation after the end of operation may be unduly prolonged.

Treatment

Treatment of aspiration is divided into (1) immediate treatment until the situation is under control; (2) subsequent treatment which deals with continued support of the vital systems and the follow-up of the patient.

Immediate Treatment—If the patient vomits or regurgitates, the table or bed is rapidly tilted to a 30-40° head-down position to have the larynx at a higher level than the pharynx and to allow gastric material to drain to the outside. The patient is also rapidly rolled to her side to confine any aspiration to the dependent lung and to facilitate drainage of vomitus from the mouth.

The mouth and pharynx should be suctioned as rapidly as possible. If solid material is found, it is scooped out, e.g., using a finger wrapped in gauze. If the patient is not paralyzed, insert a bite block or the finger might be injured. If it is difficult to open the patient's mouth, try to open the clenched jaws by using the crossed finger maneuver. If possible, avoid muscle relaxants because of the danger of combined loss of protective laryngeal reflex and paralysis of the cricopharyngeal sphincter. However, do not waste too much time in trying to open the mouth if respiratory obstruction is evident. In such cases, aspirate the pharynx with a large catheter and administer 100 percent oxygen while an assistant injects succinylcholine intravenously and applies pressure on the cricoid. Once relaxation occurs, open the mouth quickly, remove rapidly any foreign material or mucus to get a clear view of the larynx, intubate, and inflate the cuff. Following this, the assistant can release the cricoid pressure.

In all cases of suspected aspiration, laryngoscopy and intubation is performed. This is to assure a patent airway, to allow suction of aspirated material, to facilitate assisted or controlled respiration, and to prevent further aspiration. If the condition of the patient allows, suck through the endotracheal tube before administering 100 percent oxygen by positive pressure ventilation. This is to prevent pushing aspirated material beyond your reach. Suction should be brief (less than 15 seconds) to avoid cardiac arrest from hypoxia. Give 100 percent oxygen both before and after suctioning. Observe chest expansion, adventitious sounds, and change in the patient's color. Continue 100 percent O_2 administration until the patient has improved e.g. as demonstrated by arterial blood gas analysis.

Bronchial irrigation is indicated only in the obstructive type of aspiration. Five to ten mls of normal saline are instilled into the tracheobronchial tree, followed immediately by suction. It is preceded and followed by oxygenation. The sequence is repeated until the aspirated fluid is clear. Further, 200 mg hydrocortisone or its equivalent should be given intravenously.

To evacuate the stomach, a nasogastric tube should be inserted. The evacuated material should be sent for pH determination. Some workers have suggested that in patients with aspiration pneumonitis, pH of pharyngeal or tracheal aspirate reflects the original pH of aspirated fluid. But Awe et al (1966)[73] found that the pH of tracheobronchial secretions rose rapidly in dogs following aspiration

as large quantities of blood-tinged fluid, rich in protein, poured into the lumen. On the other hand, analysis of gastric juice within four hours of aspiration closely resembles that of the aspirate (Lewis et al, 1971).[58] The pH of the gastric content is of importance for treatment and prognosis of the patient. Tracheobronchial aspirate is collected in a special sterile container for culture and sensitivity determination. Give a broad spectrum antibiotic as an immediate emergency measure, such as 0.5 g tetracycline, by intravenous drip. This antibiotic should be continued until the culture and sensitivity results are reported when the most suitable antibiotic is selected.

If the patient has bronchospasm, give aminophylline, 250 mg slowly i.v., followed by 250 mg in 250 ml fluid as a drip. Rapid intravenous administration of aminophylline can cause hypotension (Goodman and Gilman, 1970).[8] Isoproterenol inhalation (0.5 mg in 3 ml normal saline) can be given via nebulizer. In patients with pronounced cardiac arrhythmia, we prefer a beta-2-agent, such as Bronkosol®*, 0.5-1 ml in 3-5 ml normal saline.

Subsequent Treatment—If aspiration occurs during induction of anesthesia for elective surgery, the operation should be postponed until the patient has recovered completely. Unfortunately, this cannot be applied to obstetric emergencies. In these situations, the delivery or operation must be expedited.

Once the initial danger of asphyxia is overcome and the patient is well oxygenated, bronchoscopy may be undertaken to ensure that the segmental bronchi are patent. It could be an immediately lifesaving procedure when solid food particles are causing obstruction. On the other hand, bronchoscopy is not an easy procedure in this situation. It can be quite traumatic and can exaggerate hypoxia if not done properly. Bronchoscopy should not be performed in every case of vomiting or regurgitation, but when necessary it should be performed by an experienced person. The history, physical examination, x-ray of the chest, and nature of the gastric contents help in deciding the indication and urgency for bronchoscopy.

In some cases of vomiting, it is apparent that there was no soiling of the respiratory tract, and all that is required is observation. In other cases, after the initial phase of cyanosis and bronchospasm, there may be an apparent improvement followed by respiratory dysfunction. Therefore, all cases with vomiting or regurgitation should be meticulously observed for at least forty-eight hours for signs of respiratory insufficiency and treatment initiated accordingly.

Mechanical ventilation via an endotracheal tube is required if the patient shows the following signs and symptoms (Bendixen et al, 1965)[74]; dyspnea, cyanosis, tachypnea, tachycardia, tracheal tug, retraction, flaring, the use of accessory muscles of respiration, PaO_2 less than 200 mm Hg on 100 percent oxygen, $PaCO_2$ higher than 50 mm Hg, arterial pH less than 7.2, increased dead space (V_D/V_T more than 60 percent), vital capacity less than 15 ml/kg, effective compliance less than 15 ml/cm H_2O. In such cases, intubation and institution of intermittent positive pressure ventilation may be of great value (McCormick, 1966[75]; Nicholl et al, 1967.[76]) The advantages of IPPV in these cases are: (1) It relieves the patient's exhaustion and dyspnea; (2) It improves alveolar ventilation ($PaCO_2$ decreases) and reduces right-to-left shunting (PaO_2 increases). (3) It is beneficial in preventing and treating acute pulmonary edema by reducing transmural pulmonary arterial pressure (Grenvik, 1966).[77] (4) It allows removal of secretions by suction.

Chemical pneumonitis can lower pulmonary compliance due to exudate, bronchoconstriction, and loss of surfactants. In such cases, ventilation with a slow rate and large tidal volume may be required. Large doses of narcotics may be required to sedate the patient and to allow control of ventilation. One must bear in mind that hypoxia is an important reason for the patient to fight the ventilator. For control of respiration, increase in oxygen concentration, initial hyperventilation and narcotics are preferred to the administration of a muscle relaxant. Tracheostomy may be required later in the course of the disease.

Inspired oxygen concentration should be high enough to relieve hypoxemia, which may cause acidosis, myocardial depression, and pulmonary edema. Therefore, inspired oxygen concentration is temporarily raised (even to 100 percent) to get a nearly normal PaO_2 of at least 70 mm Hg. Sometimes such a level of PaO_2 cannot be achieved in spite of 100 percent oxygen in the inspired mixture. In such cases, positive end expiratory pressure (PEEP) is utilized and if $PaCO_2$ is low, dead space tubing should be added or $FICO_2$ control instituted (Breivik, et al. 1973).[78] There is the possibility of oxygen toxicity when a patient is exposed to high oxygen pressure for a long time, but the dangers of hypoxia outweigh the dangers of oxygen toxicity and 100 percent oxygen must be given when required. On the other hand, inspired oxygen concentration should not unnecessarily be kept higher than required to maintain a near normal PaO_2 (Bendixen, et al 1965).[74]

Humidification of inspired gases is important since dry gases inhibit ciliary action, decrease pulmonary compliance, and cause sticky secretions that are difficult to remove. Aseptic technics and gentleness are essential for intermittent suction through endotracheal or tracheostomy tubes. Superimposed infection can lead to deterioration in the pulmonary condition of these patients. Trauma from the suction catheter and infection can also be important causes of tracheal stenosis (Adams, et al 1969).[25]

In patients who need prolonged respiratory support and have desiccated secretions, instilling a few ml of normal saline solution is often required before suctioning, in order to loosen secretions and prevent atelectasis. Administration of aminophylline, corticosteroids, isoprenaline inhalation, and removal of secretions and foreign materials help to relieve associated broncho-

* *Breon Laboratories*

spasm. Repeated determination of arterial PO_2, PCO_2, pH, and other pulmonary function tests are required to guide treatment and follow-up of these cases.

The cardiovascular condition of patients with aspiration pneumonitis should be closely monitored. Hypovolemia is suggested by tachycardia, falling blood pressure, rising hematocrit, low CVP, and decreased measured blood volumes. Hypovolemia plays an important role in the hypotension seen in these cases (Awe et al, 1966).[73] The deficit should be replaced by moderate volumes of fluids, mainly colloids. Larger volumes of electrolyte solutions restore circulation, but often at the expense of (A-a) DO_2, decreasing PaO_2 and increasing interstitial edema of the lungs.

If tachycardia and hypotension are associated with high CVP, and the latter rises more by rapid administration of 200 ml fluid, then heart failure may complicate the picture and rapid digitalization is required. After full digitalization, hypovolemia may become more evident and need correction. Also, if pulmonary edema develops at any time during the course of the disease, rapid digitalization is indicated together with other lines of treatment, such as IPPV with high inspired oxygen concentration, isoproterenol, narcotics, diuretics, IV fluid restriction, etc.

Antibiotics are required to combat infection of the respiratory system, especially if corticosteroids are administered. Because organisms in the respiratory system may change during the course of prolonged respiratory support, repeated cultures and sensitivity tests should be performed, e.g., two to three times a week.

Administration of corticosteroids have been widely accepted in the treatment of the aspiration syndrome. This inhibits the inflammatory reaction of pulmonary tissue and bronchial tree to the chemical irritation by aspirated acidic fluid and products of cell injury (Hausmann et al, 1955[79]; Marshall and Gordon, 1958[80]; Dines et al, 1961[81]; Bannister et al, 1961.[29]) Corticosteroids may improve the diffusing capacity of the lung in advanced cases that require prolonged IPPV, (Adams et al, 1969).[25] Direct instillation of hydrocortisone into the tracheobronchial tree was considered to be effective in inhibiting the inflammatory reaction (Lewinski, 1965[82]; Wamberg and Zeskor, 1966[83]), but more recently Taylor and Pryse-Davies (1968),[84] in similar experiments, found that endotracheal hydrocortisone or flucinolone did not affect the course of pulmonary pathology produced by hydrochloric acid solutions of low pH. They also found that steroids produce lesions of their own. Therefore, it is not recommended to give steroids by endotracheal instillation. The route of choice is parenterally, either intravenously or intramuscularly. After initial intravenous injection of 200 mg hydrocortisone, 100 mg every six hours is required. In certain cases, as in a patient with toxemia of pregnancy when sodium retention is to be avoided, dexamethasone may be used instead in equivalent doses (100 mg hydrocortisone = 3.75 mg dexamethasone). The duration of the treatment with corticosteroids depends on the progress of the case. Towards the end of a prolonged course, either gradual diminution of the dose and/or administration of ACTH may be required.

Prognosis

In the obstructive type, the prognosis will depend on the degree of obstruction and subsequent atelectasis, the onset of bacterial infection, the efficiency of treatment, and the resistance of the patient. The course may be quite protracted.

In Mendelson's syndrome, with proper treatment the patient usually recovers completely within twenty-four to thirty-six hours, if the pH of the aspirated material is not too low or bacterial infection supervenes. Nearly all forty cases of Mendelson's original series recovered after an afebrile illness, and only four developed pneumonia with one developing a lung abscess. Rarely does the patient rapidly develop acute pulmonary edema, heart failure, and subsequent death; but respiratory insufficiency may follow the initial period of respiratory distress and prolong the postpartum period. The main factors leading to poor prognosis are (1) low pH of gastric aspirate, (2) advanced age, (3) prolonged hypoxia, (4) pulmonary infection, and (5) previous pulmonary or cardiovascular disease.

The septic pneumonitis type has the highest mortality rate and the prognosis depends largely on the underlying disease causing intestinal obstruction.

Summary

In obstetric anesthesia, aspiration of gastric contents has been one of the leading causes of mortality and morbidity. However, during the five-year period from July 1967 through June 1972 at Magee Women's Hospital in Pittsburgh, Pennsylvania, 29,747 obstetric anesthetics were given without a single death caused by aspiration. This is essentially due to avoidance of general anesthesia whenever possible. Regional analgesia was utilized in 75.8 percent of the cases. When general anesthesia is used, the patient is considered to have a full stomach, and meticulous attention is paid to all details to avoid vomiting or regurgitation since prophylaxis as always is the best way to avoid the serious consequences of aspiration. Should aspiration still occur, early diagnosis and adequate treatment and follow-up are mandatory for recovery. In the first part of this review, the anatomy, physiology, and pathology involved in vomiting and aspiration are described in detail. Complete understanding of the basic pathophysiology is essential for diagnosis of aspiration, complete prophylactic measures, adequate therapy, and follow-up as described in the second part of this review. □

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84. **Taylor, G.; Pryse-Davies, J.** Evaluation of endotracheal steroid therapy in acid pulmonary aspiration syndrome (Mendelson's syndrome). Anesthesiology 29:17-21, 1968.

continuing education

This course listing is prepared by the Pennsylvania Medical Continuing Education Institute

CODE KEY
(indicates institution has Category One accreditation)*

*AAFP—Amer. Acad. of Family Phys. (Contact Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111)**
*ACC—Amer. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md.**
ACGP—Amer. Coll. of Gen. Practitioners in Osteo. Med. & Surg., Suite 1940, 111 W. Washington St., Chicago, Ill. 60602.
*ACP—Amer. Coll. of Phys., 4200 Pine St., Philadelphia 19104**
*AHA—Amer. Heart Assn., Pa. Affiliate, P.O. Box 2435, Harrisburg 17105**
*AMA—Amer. Med. Assn., 535 N. Dearborn St., Chicago, Ill. 60610**
*Chestnut Hill—Chestnut Hill Hosp., 8835 Germantown Ave., Philadelphia 19118**
*Clin. Path.—Pa. Assn. of Clin, Path., 1735 W. Main St., Norristown 19401**
*Coatesville VA—Coatesville Vet. Admin. Hosp., Coatesville 19320**
*Conemaugh—Conemaugh Valley Memorial Hosp., 1086 Franklin St., Johnstown 15905**
*Delaware Co.—Delaware Co. Mem. Hosp., Lansdowne Ave., Drexel Hill 19026**
*Dermatology—Pa. Acad. of Dermatology, 8220 Castor Ave., Philadelphia 19152 (c/o Charles H. Greenbaum, M.D.)**
*Einstein/North—Albert Einstein Med. Cntr./Northern Div., York & Tabor Rds., Phila. 19141**
*Elwyn—Elwyn Institute, 111 Elwyn Rd., Elwyn 19063**
*Geisinger—Geisinger Med. Cntr., Danville 17821**
*Hahnemann—Hahnemann Med. Coll., 230 N. Broad St., Philadelphia 19102**
*Harrisburg—Harrisburg Hosp., Harrisburg 17101**
M. S. Hershey—Pa. State Univ. Coll. of Med., M.S. Hershey Med. Cntr., Univ. Dr., Hershey 17033
*Institute— Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139**
*Jefferson—Jefferson Med. Coll., 1025 Walnut St., Philadelphia 19107**
*Lebanon VA—Lebanon Vet. Admin. Hosp., Lebanon 17042**
*Lehigh AHEC—Lehigh Valley Area Health Ed. Cntr., 17th & Chew Sts., Allentown 18102**
*MCP—Med. Coll. of Pa., 3300 Henry Ave., Philadelphia 19129**
*Mercy/Pgh.—Mercy Hosp., Pride & Locust Sts., Pittsburgh 15219**
*Norristown State—Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19141**
*Packer—Robert Packer Hosp., Sayre 18840**
*PAFP—Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111**
*Paoli—Paoli Mem. Hosp., Paoli 19301**
*PAO&O—Pa. Acad. of Oph. & Otol., 232 N. 5th St., Reading 19601**
PMS—Pa. Med. Society, 20 Erford Rd., Lemoyne 17043
*Radiology—Pa. Radiological Soc., 20 Erford Rd., Lemoyne 17043**
*Reading—Reading Hosp., 6th Ave. & Spruce St., Reading 19602**
*St. Margaret—St. Margaret Mem. Hosp., 265-46th St., Pittsburgh 15201**
*Temple—Temple Univ. Sch. of Med., 3400 N. Broad St., Philadelphia 19140**
*U. of Pa.—Univ. of Pa. Sch. of Med., 288 Med. Labs. Bldg., Philadelphia 19104**
*Pitt—Univ. of Pittsburgh Sch. of Med., 1022-H Scaife Hall, Pittsburgh 15213**
Roentgen Ray—Phila. Roentgen Ray Soc., Temple U. Health Sciences Cntr., Philadelphia 19140
*Warren State—Warren St. Hosp., Box 249, Warren 16365**
WP/RMP—Western Pa. RMP, 200 Meyran Ave., Pittsburgh 15213
*Washington—Washington Hosp., 155 Wilson Ave., Washington 15301**
*West Penn—Western Pa. Hosp., 4800 Friendship Ave., Pittsburgh 15224**
*York—York Hosp., George St. & Rathton Rd., York 17405**

Key to symbols:
( ) Indicates the PRA Category Number in which attendance at this program should be reported. You may report each hour of attendance.
Bold Face Type indicates an institution that has Category I accreditation. This name MUST APPEAR on your PRA APPLICATION to the AMA if you are to receive Category I credit.
In most cases each of the following continuing medical education activities has been granted AAFP and ACGP (Osteopathic) credit. Contact those offices for details.

CME PROGRAMS
Listed below are programs of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, the instructor, the frequency of sessions, fees, maximum registration, etc., contact the director at the address given in the course listing or in the CODE KEY box.

New Castle; Apr. 2, 1974 - Mar. 4, 1975
(1) Continuing Education for Physicians; by **Pitt.** and Lawrence Co. Med. Soc.; at New Castle Country Club. Contact: James N. Bower, M.D., Chrm., Cmte. on Cont. Med. Educ., Temple Bldg., New Castle 16101.

Wilkes-Barre: Luzerne Co. Med. Soc.; Sept. 11 - Nov. 13, 1974
(1) Chronic Liver Disease; by **Hahnemann;** Sept. 11, 1974
(1) Diagnosis and Management of Acid Base Disorders; by **Hahnemann;** Oct. 9, 1974.
(1) Respiratory Failure: Diagnosis and Management; by **Hahnemann;** Nov. 13, 1974.
Contact: Leona O. Franey, Exec. Secy., 130 S. Franklin St., Wilkes-Barre 18701.

Wilkes-Barre; at Mercy Hosp.; '73-'74 Academic Year
(1) Nuclear Medicine as it Relates to Family Practice; by **PAFP;** Apr. 24, 1974
(1) Current Concepts on Use of Female Hormones in Family Practice; by **Jefferson;** May 9, 1974.
(1) Use of Female Hormones for Various Female Disorders; by **Jefferson;** May 23, 1974.
Contact: J. P. Brennan, M.D., D.M.E., Mercy Hosp., 196 Hanover St., Wilkes-Barre 18703

Wilkes-Barre; Wilkes-Barre Gen. Hosp.; Apr. 4- June 26, 1974
(2) Family Practice Conference; first Thurs.
(2) Medical; Thursdays
(2) Surgical; Wednesdays
(2) Pediatrics; second Tues.
Contact: Lester M. Saidman, M.D., D.M.E., Wilkes-Barre Gen. Hosp., Wilkes-Barre 18703

Wilkes-Barre; at Wyoming Valley Hosp.; Mar. 27 - May 22, 1974
(1) Twenty-fifth Postgraduate Seminar; by **PAFP** and Luzerne County Chapt. of Family Physicians. Contact: D. W. Kistler, M.D., 245 E. South St., Wilkes-Barre 18702

Williamsport Hospital; 1973-1974
(1) Medical & Surgical Grand Rounds; each Saturday; by **U. of Pa.**
(1) Continuing Education Program; second Friday ea. mo.; by **U. of Pa.**
Contact: Herman W. Rannels, M.D., Vice President & Med. Dir., Williamsport Hosp., 777 Rural Ave., Williamsport 17701.

COURSES

CHEST DISEASES
June 19, 1974; Coatesville
(1) Pulmonary Physiology, Pathology and Diagnosis; at **Coatesville, VA;** cosponsored by **Paoli** & Chester Co. Med. Soc. Contact: J. Clifford Scott, M.D., Dir. of Prof. Educ., Coatesville, V.A.

PLEASE NOTE: The following listings are all new listings that have been received since the last publication of "Continuing Education" in PENNSYLVANIA MEDICINE. Listings from the October and December 1973 editions and the January and March 1974 editions need to be integrated with the following to give a complete calendar.

Oct. 28 - Nov. 8, 1974; Philadelphia
(repeat Feb. 3 - 14, 1975)
(1) Postgraduate Course in Bronchoesophagology; at **Temple.** Contact: Chevalier Jackson Clinic, Temple.

GASTROENTEROLOGY

Sept. 13 - 14, 1974; Philadelphia
(1) Fiberoptic Colonoscopy—A Multidisciplinary Symposium; by **Jefferson;** at Philadelphia Marriott Motor Hotel. Contact: John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson.

METABOLISM

May 15, 1974; Darby
(1) Diabetes Mellitus; at Mercy Catholic Med. Cntr.; by **Jefferson.** Contact: D. J. Hilferty, Jr., M.D., Dir. Cont. Med. Educ., Mercy Catholic Med. Cntr., Darby 19023.

NEUROLOGY

Oct. 16, 1974; Coatesville
(1) Biological Considerations in the Treatment of Neuropsychiatric Conditions—17th Annual Neuropsychiatric Institute; at **Coatesville, VA:** cosponsored by **Jefferson** & Chester Co. Med. Soc. Contact: J. Clifford Scott, M.D., Dir. of Prof. Educ., Coatesville, V.A.

RADIOLOGY

May 31 - June 1, 1974; Pittsburgh
(1) Nuclear Medicine Review; at **Pitt.** Contact: William M. Cooper, M.D., Dir. Div. of Cont. Educ., Pitt.

SPORTS

May 17, 1974; Pittsburgh
(1) Third Annual Sports Medicine Symposium; by **Pitt.**; at William Penn Hotel. Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

SPECIAL ANNOUNCEMENT

Beginning in September, continuing medical education listings will be published only twice a year in a special continuing medical education supplement to PENNSYLVANIA MEDICINE.

September and January will be the issues that will carry this supplement. It will include the full Medical Education Calendar that heretofore has not been printed in PENNSYLVANIA MEDICINE.

Deadlines, for listings that you want included, will be:

June 15 for September
October 15 for January

For more information, contact:

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*AVAILABLE ON REQUEST: Ronald T. Goldberg, M.D. & Franklin T. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

Flood revisited

Lessons 'unlearned' from Hurricane Agnes

WILLIAM F. BOUZARTH, M.D.
Philadelphia

In 1972, Hurricane Agnes inundated parts of Pennsylvania. The Wyoming Valley was particularly hard hit. In response, the 1972 PMS House of Delegates resolved "that the Pennsylvania Medical Society design and maintain effective liaison with county medical societies in the establishment and implementation of an Emergency Medical Communications System, or Clearing House, for disasters that may occur in the future in our Commonwealth, and be it further *RESOLVED* that in developing an 'Emergency Medical Communications System,' efforts to include the Pennsylvania Osteopathic Medical Association and the Pennsylvania Pharmaceutical Association are most essential." This task was delegated to the Commission on Emergency Medical Services.

Until 1968, a commission on disaster medicine functioned under the Council on Public Service, at which time it was transferred to the Council on Education and Science and renamed the Commission on Emergency Medical Services. This new commission understood that any emergency medical service plan for the Commonwealth should include disaster medicine.[1]

In response to the 1972 House action, the commission prepared a one-page questionnaire to investigate county medical societies' emergency medical and disaster plans. As of this writing, only twelve of the sixty-seven counties have returned the form. Therefore, the commission decided that another method should be found to implement the House resolution.

The next approach was a review of the response in Dauphin and Luzerne Counties to the crisis of Hurricane Agnes. The Dauphin County Medical Society's executive secretary gave a prompt and thorough presentation to the commission. The Dauphin County Society was requested to outline the response of the medical community in the Harrisburg area to Hurricane Agnes for publication in PENNSYLVANIA MEDICINE, but this effort was unsuccessful. The commission's appraisal is that medical communication in Dauphin County (including the Medical Bureau Answering Service) was not interrupted. Medical care was available except where there was a delay in moving patients from the flooded areas. Although there were delays—there were no major problems. The doctors of the Dauphin County Medical Society are to be congratulated for a job well done. The commission, however, is concerned that if the Medical Bureau Answering Service telephones had become inoperable, a major medical disaster could have occurred.

The commission traveled to Wilkes-Barre to meet with selected members of the Luzerne County Medical Society approximately one year after the flood. By then many of the anecdotal experiences had lost their flavor, and the commission could concentrate on hard facts. It was confirmed by the end of that meeting that two important elements were lacking in Luzerne County—command and communication. In Wilkes-Barre the flooding had been more severe, and telephone service had been disrupted both within the immediate area and in nearby communities. The radio networks set up by Civil Defense were housed in a sub-basement in one of the lowest points in Wilkes-Barre—one of the first areas to be flooded. The same was true of the answering service in the county medical society building. Incidentally, this situation would recur in the event of another major flood.

Direct links to the outside world from Wilkes-Barre were via television and radio from Scranton. This caused unexpected problems, since any radio or TV request for medical support produced an exaggerated response from distant communities. One doctor in a school first-aid station requested a dozen tetanus booster shots. Instead he received 1,000. When ten cots were requested, a hundred arrived. Supplies, often of the wrong kinds, piled up in various areas; while some needed supplies came too late. A request by a young lady for birth control pills was quickly honored, but the quantity received was adequate for half of the community.

Another communications problem was that some doctors turned to Civil Defense, others to the medical society. Yet neither medical command maintained a base of operation, making effective location impossible. Two hospitals evacuated their patients to another institution. Soon thereafter elderly people from a nearby nursing home were evacuated to one of the hospitals which had just been emptied. These conflicting events apparently occurred because of independent, uncoordinated medical decisions.

Another enigma was the abuse of sirens by ambulances and medical groups, since there were very few real medical emergencies during the flood. Fatigue compounded the problems—especially for the praiseworthy young volunteers. As the hurricane reached disaster proportions, these dedicated young people worked around the clock and inevitably became ineffective, disgruntled, and disorganized. An important responsiblity of medical command would be to require workers to sleep eight hours out of every twenty-four.

Although the commission did not evaluate the role of government in the flood, it appeared that the local government was too busy reacting to problems

Dr. Bouzarth is chairman of the Society's Commission on Emergency Medical Services and of the Commonwealth's Comprehensive Health Planning Task Force on Emergency Health Services. He is a neurosurgeon on the staff of Episcopal Hospital, Philadelphia.

presented to them to prevent further problems from occurring. State government agencies seemed to be ineffectual, both because they had no prepared disaster plan and because they could not communicate with area physicians and vice versa. The federal government responded to the diaster in a magnified way—dumping supplies and help. A member of the U. S. House of Representatives decided that typhoid inoculations were needed, and an appeal was broadcast by radio and television. Public health experts considered, both at the time and in retrospect, that typhoid inoculations were unwarranted, but it was difficult to persuade the public that radio reports were inaccurate. In addition, the military refused to let people return to their homes after the flood subsided unless they could show proof of recent typhoid inoculation. Coordination between various government and nongovernment organizations providing disaster relief was lacking.

Nor was the Pennsylvania Medical Society immune. Apparently, the Board of Trustees took action on the executive level without consultation with the Commission on Emergency Medical Services. Communication between the Board and the commission was impossible because of flooding in Harrisburg.

In summary, everybody did a good job under the circumstances and medical care was *not* lacking. Deficiencies which existed then can be avoided in the future by expert preplanning. Command and Communications must be the backbone of any disaster plan. The Philadelphia Regional Emergency Medical Disaster Operations Plan stresses this point,[2] but those who designed the plan are quick to point out that should telephone communications be lost in the Philadelphia area, the plan would inevitably be less effective. Ideally, counties or areas should develop command posts using two-way radio communication to the area hospitals, medical society answering services, police and fire departments, municipal government, Civil Defense, and others. There should be a mechanism in the command post to communicate with medical facilities away from the disaster area, and all medical supplies should be distributed under the direction of the command post. The commission is concerned about implementation of such a program except in isolated parts of the Commonwealth because of lack of interest at the county medical society level. Nevertheless, the Pennsylvania Medical Society, the Pennsylvania Osteopathic Medical Association, the Pennsylvania Pharmaceutical Association, the Hospital Association of Pennsylvania, the Pennsylvania Department of Health, civil defense officials, and others should reconvene in an attempt to develop a medical disaster plan in the event Hurricane Agnes or another, perhaps larger, disaster occurs.

Since money and dedication are needed to prepare an adequate medical disaster plan for Pennsylvania, perhaps the Governor's Office should take on this responsibility.

REFERENCES

1. "Emergency Medical and Health Services in Pennsylvania." PENNSYLVANIA MEDICINE, June 1971.

2. **Bouzarth, W.F.; Mariano, J.P.** Philadelphia Regional Emergency Medical Disaster Operation Plan (PREMDOP.) Archives of Environmental Health, 18:203, 1969.

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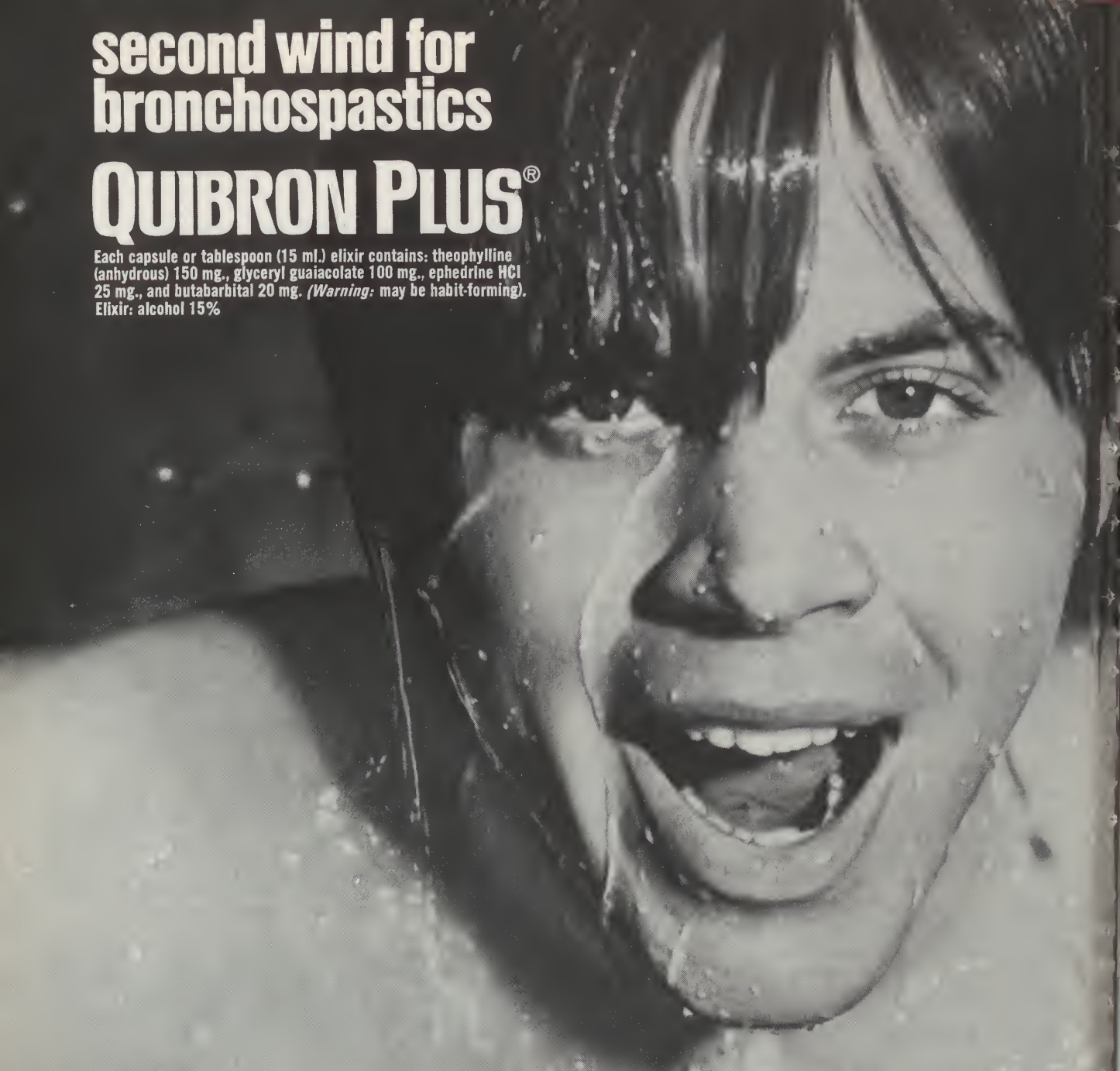

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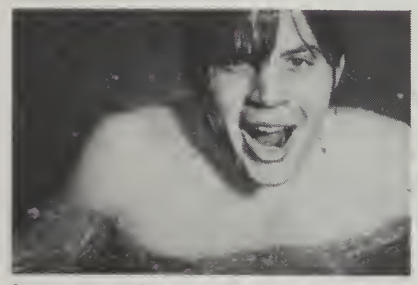

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The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

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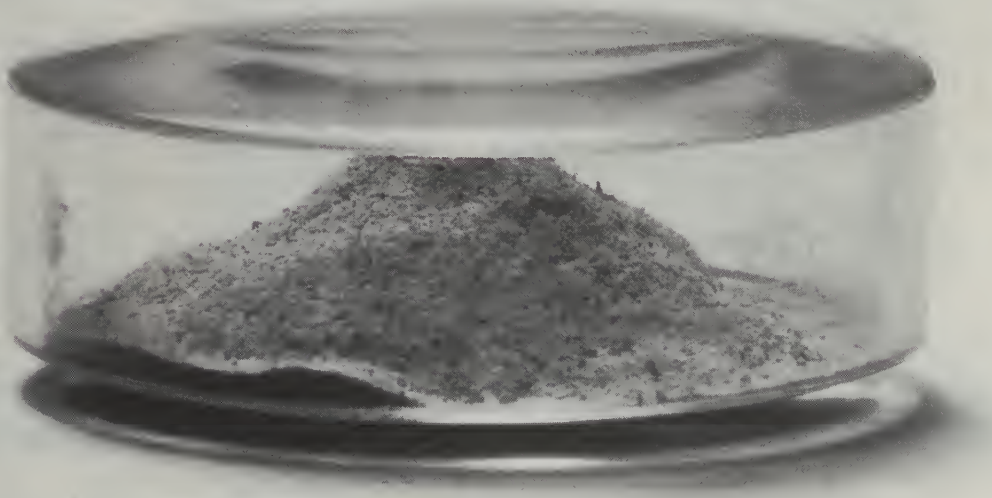

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Topic: "Surgery Training: Past and Future"

Speaker: John Y. Templeton III, M.D., Professor of Surgery, Thomas Jefferson University; President, Philadelphia County Medical Society and the Philadelphia Academy of Surgery

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REFER TO PDR

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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to help reduce clinically significant anxiety and thereby help improve patient receptivity

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up to 100 mg daily in severe anxiety

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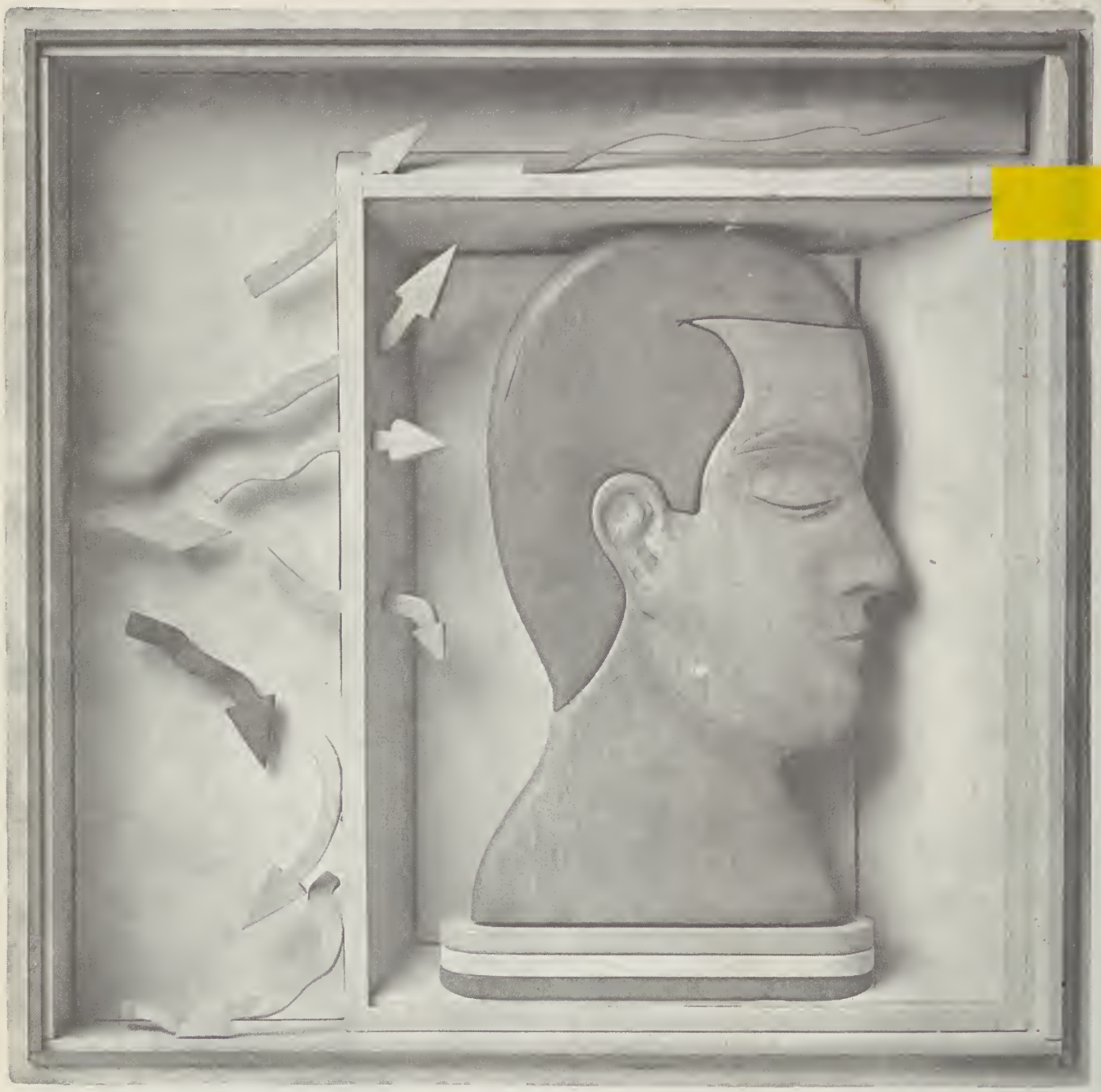

Symptom of excessive anxiety:

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Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician-patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

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FACING MEDICINE'S GRAVEST PROBLEM

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PHYSICIANS CAUTIONED ON FEE INCREASES The Board of Trustees on May 15 adopted a recommendation that "members examine their fees in light of their costs; that they view themselves as economic forces in the community where they live and serve; and that they relate their fees to the economic realities of their practice in such a way that they can freely discuss them with their patients." The demise of Phase IV restrictions on the health industry caused the Board to adopt the statement and to further urge that members of hospital medical staffs take the message of cost moderation into the hospitals where they work.

BOARD ADOPTS HEALTH CARE POLICY STATEMENT A policy statement on Pennsylvania's health care matters to be presented to both major political parties was approved by the Board of Trustees in May. It calls for the establishment of a strong Department of Health, a separate Department of Mental Health, and passage of the Medical Practice Act. The full text of the position paper will appear in the August issue of PENNSYLVANIA MEDICINE.

BOARD SUPPORTS ACUPUNCTURE LEGISLATION The Board of Trustees gave its support to H.B. 2314, new legislation which would permit acupuncture only by physicians or persons directly supervised by physicians and places regulation of acupuncture under the State Board of Medical Education and Licensure.

DPW DEPUTY RESIGNS William B. Beach, Jr., M.D., deputy secretary for mental health and medical health services in the Department of Public Welfare has resigned effective June 4. His successor has not yet been named. He has accepted a position as director of a psychiatric hospital in Vermont.

HMO REGULATIONS PUBLISHED The Department of Health, Education, and Welfare May 8 published proposed regulations implementing the Health Maintenance Organization Act of 1973. Established prepaid group practices are expected to request time to phase in mandatory benefits which they do not now offer. The April and May issues of PENNSYLVANIA MEDICINE carried articles explaining the new law.

MALPRACTICE HEARINGS SCHEDULED A. Reynolds Crane, M.D., Society president elect, will testify for the Society at hearings scheduled by the Insurance Department June 17 and 18 in Philadelphia on the subject of medical malpractice loss prevention programs. Representatives of Argonaut Insurance Co., underwriter of the Society's program, will explain its Medical Alert Communications--a service for all insured physicians, malpractice seminars, and other loss prevention activities.

ARGONAUT TO SEEK RATE INCREASE Sometime after the June 17-18 malpractice hearings in Philadelphia, Argonaut Insurance Co., underwriter of the Society's professional liability insurance program,

will seek an increase in rates. Current rates are five years old. At its May meeting the Society's Board of Trustees endorsed a recommendation from the Commission on Professional Liability Insurance that the rate increase be supported. Exact amounts will be set after the hearings.

ACUPUNCTURE TRAINING COURSE APPROVED A clinical training program in acupuncture therapy for physicians has been approved by the Pennsylvania State Board of Medical Education and Licensure. To be conducted by Teruo Matsumoto, M.D., professor of surgery at Hahnemann Medical College and Hospital and other physicians with extensive background in acupuncture therapy, the first course begins at Hahnemann the first Tuesday in August and continues every Tuesday and Thursday from 6 to 8 p.m. and Saturdays from 1 to 5 p.m. for a total of 8 hours per week for 4 weeks. The course conforms with Board policy in that it will be conducted on a research basis in the clinical setting of a medical school.

PARKER NAME CHANGE ANNOUNCED Parker & Company Inc. of Pennsylvania, administrator of the Society's professional liability insurance program, has a new name: Frank B. Hall & Co. of Pennsylvania Inc. While the name change announcement is news, Parker has been a division of Frank B. Hall, one of the world's largest insurance brokerage organizations, for several years. The professional liability insurance program remains the same.

NEW YORK MALPRACTICE SCENE BRIGHTENS With a new malpractice mediation bill mandating that all medical malpractice suits be submitted to a mediation panel before a plaintiff can go to trial, and with a new underwriter for the professional liability insurance program of the state society, the grim malpractice scene in New York looks brighter. Argonaut Insurance Co., underwriter for the PMS professional liability insurance program, has agreed to assume indemnity responsibilities July 1, 1974. The action followed an announcement by Employers Insurance of Wausau that it could continue participation in that state society's program only until a new program could be negotiated. Several other large insurance companies will combine with Argonaut to provide coverage.

PSRO PLANNING CONTRACT APPLICATIONS FILED Eight Professional Standards Review Organizations in Pennsylvania (in areas II, IV, VI, VII, VIII, IX, XI, XII) have filed planning contract applications with the Department of Health, Education, and Welfare and should be receiving answers during June. Of the remaining four areas, three (I, III, and V) have formed steering committees which are preparing applications with the assistance of the Pennsylvania Medical Care Foundation in its role as Peer Review Advisory Center.

WHO IS ELIBIBLE TO USE HOSPITAL SERVICES? The Board of Trustees of the Hospital Association of Pennsylvania has approved a statement urging member institutions to honor requests for diagnostic and treatment services of only those professional individuals whose qualifications meet the requirements for admission to the hospital staff as provided by the hospitals' bylaws. The statement came in answer to a question concerning the use of hospital facilities--principally laboratory and X-ray services--by chiropractors in the Commonwealth. This supports the position adopted by the State Society on this matter.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

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Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—**Inject 5 ml intramuscularly** for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—**Inject 10 ml intramuscularly** for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
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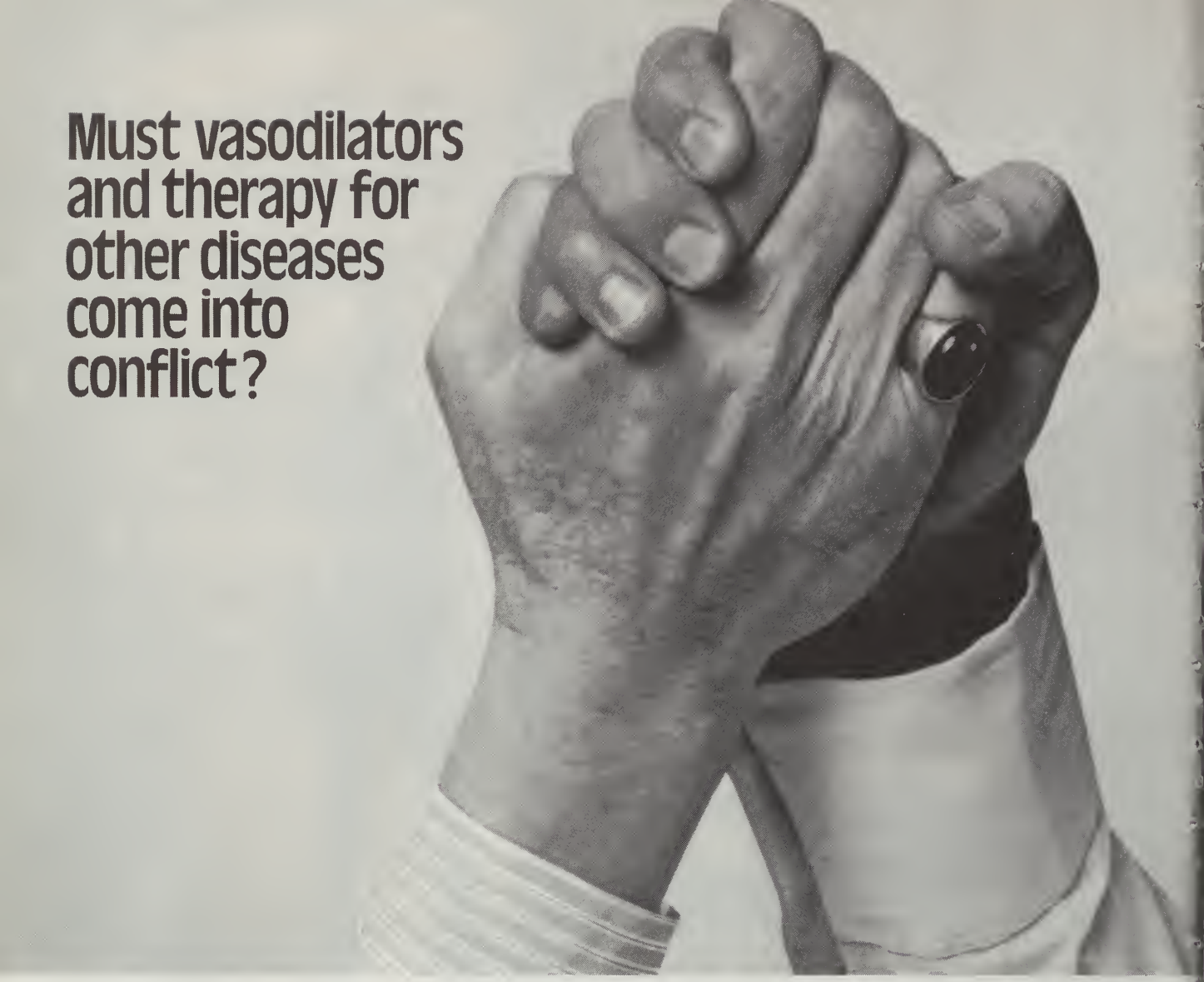
† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes... yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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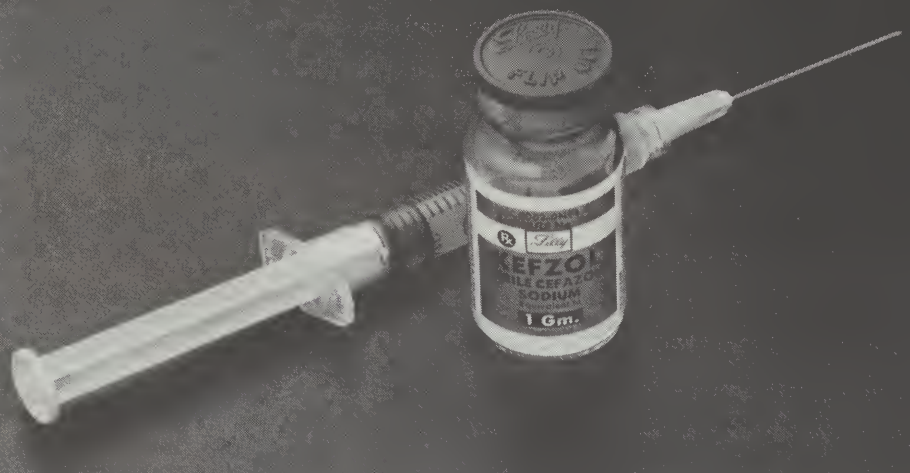
Ampoules, equivalent to 1 Gm. of cefazolin



Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206
400380

Success marks practice management seminar

The success of the Society's practice management seminar at Hershey May 10-11 led immediately to the planning of a repeat performance, tentatively scheduled for November in Pittsburgh. One hundred participants, shown to the right, learned that careful planning and effective management does improve the physician-patient relationship and the ability to deliver quality health care. Panelists (in the top photo, left to right) Roger Harrison, Leif C. Beck, Ll.B., and Thomas E. Zirkle all are professional management consultants. The Society's legal counsel, Fred Speaker, Esq., participated in the presentation. A limited number of copies of the textbook prepared especially for the seminar are available from the Council on Education and Science. Price is $10.

Category One extended

Five more Pennsylvania hospitals were granted accreditation of their continuing education programs at an April meeting of the Commission on Accreditation of the Pennsylvania Medical Society.

The following hospitals were given authority to grant Category One credit toward the American Medical Association Physician's Recognition Award and the PMS membership requirement.

Harrisburg
Harrisburg Polyclinic Hospital
Philadelphia
Eastern Pennsylvania Psychiatric Institute
Jeanes Hospital
Phoenixville
Phoenixville Hospital
Pittsburgh
St. Francis General Hospital

Dr. Grandon heads PSIM

Raymond C. Grandon, M.D., New Cumberland, was installed as president of the Pennsylvania Society of Internal Medicine (PSIM) at its annual banquet on March 29. He succeeds Peter L. Saras M.D., of Hazleton.

A past secretary and treasurer of PSIM and former president of its central region, Dr. Grandon currently serves as a member of the Society's Council, Executive Committee, and as delegate to the American Society of Internal Medicine.

He is president of the Medical Bureau of Harrisburg, member of the Board of Trustees and Councilors of the Pennsylvania Medical Society, and a member of the State Board of Medical Education and Licensure.

Other officers elected for the 1974-1975 term are James R. Regan, M.D., Bethlehem, treasurer, and Peter N. Hillyer, Paoli, secretary.

YOU can play a part in reducing those mountains of medicare paper by following the author's checklist . . . This is 'must reading' for you and your office staff as is the author's previous medicare article on page 14 of the January 1974 issue

How to reduce medicare paperwork

I.R. PERKIN
Camp Hill

Doctors are telling Pennsylvania Blue Shield (PBS) in no uncertain terms that they are fed up with paperwork. This theme recurs again and again in our daily contacts with the medical community.

Doctors are annoyed, confused, and often bewildered by paperwork requirements. Resentment mounts as paperwork makes more demands on their time. They feel that the time spent on forms does not contribute in any way to the practice of medicine, and they feel it encroaches on their prerogatives as practicing physicians.

We at Blue Shield appreciate this concern. Paperwork is the vital communications link between doctors and our company. We feel the problem is a mutual one since the more we can simplify and ease this workload, the better we will be able to process and pay claims.

But, why the problem in the first place? Can it be reduced or at least contained? We believe so.

Recognizing that medicare is a federal program paid for with public money, the specific accountability requirements of the law are easy to understand. The Medicare Law provides for payment for medically necessary services on a reasonable charge basis. (This was explained in the article which appeared in the January issue of *Pennsylvania Medicine*.) The information needed to process and pay medicare claims stems directly from these accountabilities. A third requirement, inherent in most situations where the exchange of money for services takes place, is the need to determine eligibility for medicare benefits.

Generally, we find that doctors and their office assistants who take the time to really analyze and do their paperwork with these broad requirements in mind have very few complaints. They have little difficulty in their dealings with Blue Shield. The paperwork exchange with us is minimized because the information we need is on the claim when it first comes in. We don't have to call or write for additional facts. This means that their claims can be processed promptly.

Let's look at some specifics which can help you and your office assistant ease your medicare paperwork headaches. What can the doctor do? What should his office assistant, nurse or bookkeeper be expected to know? What pitfalls should be avoided? How can we improve the communication between you, the provider, and PBS, the agency

responsible for payment? Here are seven simple tips which, if followed, can go a long way toward alleviating the problem.

Show Type of Visit on Bill

Payment is delayed on one out of every ten claims received because we must contact the doctor or patient to obtain missing information. With an average of 13,000 claims coming in every day this means, at a minimum, 1,300 more pieces of paper shuffled daily just to obtain information missing on original claims.

Heading the list of items missed is the absence of an indication of the *Type of Visit* for which reimbursement is claimed. Why should this be described?

Doctors' profiles, which form the basis of payment, are developed and recorded from past charges for medical care visits categorized as brief, intermediate, or extended. If you don't tell us the type of visit, we can't relate the reported service to your profile. Result: DELAY. Plus, your paperwork load as well as ours grows when we try to obtain the needed information. (Page 50 of your copy of the Pennsylvania Blue Shield Procedure Terminology and Manual spells out definitions in case there is any question on how to report *Type of Visit*.)

Itemize your Bills

Next on the list of inhibitors to prompt payment is the need for itemized charges. Again, doctors' profiles used to determine payment are based on charges for individual services. We thus are unable to relate charges for *grouped* services to profiles for payment. We must know your charge for each service reported.

Further, when you charge for laboratory services, tell us *where*

Doctor, you and your office staff *can* reduce medicare paperwork—here's how. Be sure to read this article and make it available to your aides.

the service was performed. If it was done in an independent laboratory—show the address (we need this to resolve duplicate billing and certification problems that frequently arise.)

State Diagnosis

We need a stated diagnosis in order to determine that the services were medically necessary. When it is impossible to state a diagnosis, provide a brief statement of physical findings and/or symptoms to indicate that services provided (especially laboratory work) were medically necessary.

State Circumstances for Unusual Services

The medicare program has certain limitations on services for *chronic* conditions. When a case is *acute,* or involves unusual circumstances, the limitations are less severe. Thus, higher levels of care (extended visits rather than brief or intermediate) or increased frequency of service (numerous or daily visits) should be explained. Claims processing is simplified when you relate extra charges or services to unusual circumstances.

Use a Typewriter

Deciphering poor handwriting is a continuing problem. Claims are sometimes delayed because of illegible writing. Have your claims or bills typed if at all possible. If you can't have them typed, please print. Of the claims received last year, nearly half of the assigned and 80 percent of the nonassigned were handwritten. Extra paperwork caused by poor handwriting can be substantially reduced if the information you give us is typed or, at least printed.

Use Blue Shield's Procedure Terminology

The Pennsylvania Blue Shield Procedure Terminology and Manual is the basic handbook for both your reporting and our internal processing. It lists over 4,500 services and procedures and their procedure code numbers. When you use this terminology and the code number, we know exactly what service or procedure you performed and can determine quickly what to pay. When you submit a claim or give a medicare patient a bill, be sure to use both the procedure code number and the short, explanatory terminology. (Look for an improved manual this summer. It will contain some short-cuts to ease your reporting workload.)

Complete the SSA Form 1490 Properly

The SSA Form 1490 is the basic Request for Medicare Payment form. On assigned claims (and non-assigned when the 1490 is used as your bill) we must have both doctor and patient signatures. We also need the patient's complete address and health insurance claim number.

You can help by accepting assignment and making sure the form is properly completed. Older medicare beneficiaries are particularly grateful for this assistance. Even if you don't accept assignment, you can still make sure the Medicare Request for Payment form is properly completed. Simply use it as a bill, marking the "do not accept assignment" block and give it to your patient. These Medicare Request for Payment forms are furnished with your name and identification number preprinted at no charge. You can save money on printing costs by using them.

The accompanying illustrations show how the same services are reported using either the Medicare Request for Payment form or a typical doctors billing form. Adjacent notes point up some of the tips discussed above.

Summary

To summarize, paperwork *can* be reduced. The best *over-all* tip we can give is to recognize (and accept) the fact that your report (the 1490 or your bill) is an important element of the medicare program. It determines how and when you or your patient gets paid. To minimize your paperwork "do it right the first time" by making sure your report answers—briefly, accurately, and legibly—the classic reportorial checklist questions of:

WHO	(Name of doctor and patient)
WHAT	(Itemized services)
WHEN	(Dates of services)
WHERE	(Place of service)
WHY	(Diagnosis or symptoms)
HOW	(How much - Itemized charges)

Mr. Perkin is director of medicare operations for Pennsylvania Blue Shield. This is the second of two articles dealing with how Pennsylvania Blue Shield reviews medicare claims. The first article appeared on page 14 of the January 1974 issue of PENNSYLVANIA MEDICINE.

REQUEST FOR MEDICARE PAYMENT

Form Approved OMB No. 72-R0730

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:
Medicare (00865)
Pennsylvania Blue Shield
Box 65 Blue Shield Bldg.
Camp Hill, Pa. 17011

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name): John Doe

2 Health insurance claim number (Include all letters): 1 2 3 4 5 6 7 8 9 A — ☒ Male ☐ Female

3 Patient's mailing address: P. O. Box 2972 — City, State, ZIP code: Camp Hill, Pa. 17011 — Telephone Number: 555-2554

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below) — Was your illness or injury connected with your employment? ☐ Yes ☒ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.
Insuring organization or State agency name and address — Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE — Signature of patient (See instructions on reverse where patient is unable to sign) — Date signed: 4/20/74

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
1-26-74	O	90020 - Office visit intermediate examination, evaluation and/or treatment	Acute upper respiratory infection	$ 10.00	
1-26-74	IL	80012 SMA-12	"	10.00	
1-30-74	IH	31500 - Emergency endotracheal intubation, central venous catheter placement	Respiratory failure Emergency admission to hospital	150.00	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No. 555-1112 — Physician or supplier code J000001

9 Total charges: $170.00
10 Amount paid: $ -0-
11 Any unpaid balance due: $170.00

12 Assignment of patient's bill: ☐ I accept assignment (See reverse) ☒ I do not accept assignment.

13 Show name and address of facility where services were performed (If other than home or office visits): Johnston Laboratory 111 N. 10th St. Hbg., Pa. — Holy Spirit Hosp. Camp Hill, Pa.

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction): T. Jones — Date signed: 5/18/74

*O—Ooctor's Office IL—Independent Laboratory H—Patient's Home (If portable X-ray services, identify the supplier) IH—Inpatient Hospital ECF—Extended Care Facility OH—Outpatient Hospital OL—Other Locations NH—Nursing Home

FORM SSA-1490 (8-72) Department of Health, Education, and Welfare Social Security Administration

"TIPS"

Show Type of Visit on Your Bill

Itemize Your Bill

State Diagnosis

State Circumstance for Unusual Services

Use A Typewriter

Use The UPT Manual

T. Jones, M.D.
P.O. Box 65
Camp Hill, Pa. 17011

I.D. # J000001 Phone 555-1112

April 20, 1974

Mr. John Doe
P.O. Box 2972
Camp Hill, Pa. 17011
HIC # 123-45-6789A

FOR PROFESSIONAL SERVICES

1-26-74 O 90020
Office visit, intermediate examination, evaluation and/or treatment - $10.00

1-26-74 IL 80012
SMA-12 (Sent to Johnston Laboratory, 111 N. 10th Street, Hbg., Pa.) - $10.00

1-30-74 IH 31500
Emergency endotracheal intubation, central venous catheter placement (Holy Spirit Hospital, Camp Hill, Pa.) - $150.00

Acute upper respiratory infection.
Respiratory failure - emergency admission to hospital 1-30-74.

Medical cooperative gains momentum

More than 450 Pennsylvania Medical Society members have now joined the Pennsylvania Medical Cooperative, the newest member benefit offered by the State Society.

The goal of the membership recruitment drive, less than two months old, is to recruit 2,000 as a necessary base for operations. An initial informational mailing, follow-up telephone solicitations, and a ten-minute slide show for presentation to county medical societies have been used to explain details to members.

Operation will not begin until 2,000 members have joined through a $100 lifetime membership fee. It is expected this goal may be reached by fall of this year, enabling activation of the cooperative within six months. A governing board (the majority from the co-op membership at large) must be elected, bylaws finalized, personnel hired, and warehouse space contracted.

Savings for the first line of brand name medical supplies should amount to between 30 and 50 percent. If the cooperative proves as beneficial to members as the State Society expects, a second line of products, including surgical supplies and higher cost items, should generate even greater savings.

It is important to note that the exact products carried will be determined by the membership itself, generating larger savings from the items of greatest demand.

Inventory control contracts will be offered to interested members. An evaluation of each physician's use of supplies and available storage space will provide automatic resupply, producing further savings in the physician's office staff time.

Out-of-state medical societies are currently studying plans for the development of their own cooperatives. It is not inconceivable that a national medical cooperative could result.

For further information on the Pennsylvania Medical Cooperative, contact Riegel Haas at Society headquarters.

Six year program planned

Lehigh University and Medical College of Pennsylvania (MCP) have announced a joint program incorporating a bachelor of arts degree in biology and a medical degree in six years.

Beginning in September 1974, the first two years will be spent at Lehigh with a basic biology-oriented course; the second two years will be medical student training at MCP; and the final two years will be in clinical medicine either at MCP or one of its affiliated hospitals.

The program is so constructed that students could transfer to other courses at the end of the first two-year period if they choose not to continue. Those who do continue would have earned a B.A. from Lehigh by the completion of the second two-year period and a combined B.A. and M.D. degree at the end of the entire six-year period.

Inquiries regarding the program may be directed to Samuel H. Missimer, director of admissions at Lehigh University.

RALPH C. WILDE, M.D., president of the Pennsylvania Medical Society, speaks with participants at the Woman's Auxiliary Annual Conference held at the Host Inn in Harrisburg in April. They are (left to right): Mrs. Raymond C. Grandon, president elect of the woman's auxiliary; Mrs. Frederick R. Gilmore, president; Mrs. John K. Kitzmiller, conference co-chairman; and Elizabeth Elmer, assistant professor of the department of psychiatry at the University of Pittsburgh School of Medicine, who spoke on child abuse. Dr. Wilde brought the Society's official greetings to conferees.

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editorials

Support the Foundation

In October of 1970, the Pennsylvania Medical Society's House of Delegates approved the establishment of the Pennsylvania Medical Care Foundation. The stated purposes of the Foundation were then, as they are now, to initiate a program in Pennsylvania which would meet the requirements of the Bennett Amendment for Professional Standards Review Organizations and national HMO legislation. One of the objectives empowered the Foundation to "negotiate, establish, and carry out contracts consistent with the Foundation's purposes with any person, group, association, or corporation or any branch or subdivision of local, state, or national government." It was hoped that when PSRO legislation was enacted, the Foundation would be in a position to serve as a state-wide agency to coordinate activities in Pennsylvania.

At a special session of the House of Delegates in Harrisburg, June 9-10, 1973, regarding PSRO, the Council on Medical Service recommended "that the House of Delegates designate the Pennsylvania Medical Care Foundation as the official organization responsible for assisting in an advisory capacity in the implementation of the Bennett Amendment in Pennsylvania."

The efforts of the State Society through the Pennsylvania Medical Care Foundation have produced significant results. It was announced on March 31, 1974, that the Foundation has been awarded a contract by the Department of Health, Education, and Welfare for $243,295. It is intended that the grant will be used to aid in the organization of PSROs in Pennsylvania. Pennsylvania has the distinction of being the first state to have a state-wide Peer Review Advisory Center funded by the federal government in compliance with the standards of the Bennett Amendment.

It is incumbent upon the physicians of Pennsylvania, medical and osteopathic alike, to make this pilot project work to the benefit of both the public and the medical profession. It is our responsibility to see that the taxpayer's money does provide quality health care to our patients. Likewise, we must try to avoid the introduction of a bureaucracy which is often fostered and fed by federal appropriations. Such a bureaucracy can only add to inefficiencies unresponsive to the needs of the profession and patients and will be concerned only with rigid rules and regulations regardless of the influence on patient care.

As physicians, we are now in a situation whereby we may either serve our patients and our profession by cooperation or refuse our assistance and pave the way for nonprofessional controls. Who knows better what is in the best interest of the patient than the practicing physician? It is wiser to invest time and effort in the Pennsylvania Medical Care Foundation now than to find that, at some point in the future, the government is telling the doctor what is best for his patients.

David A. Smith, M.D.
Medical Editor

correspondence

Let's use acupuncture

To the editor:

I read with considerable interest the article on acupuncture by Dr. Matsumoto. Several comments on the substance and conclusions are warranted. First the study on cervical and lumbar osteoarthritis deals with a paltry number of patients. The extent of symptomatology including presence or absence of radiculitis, previous surgery, aggravating factors, age groups, compensationitis, psyche, etc. are not mentioned.

These conditions are characteristically intermittently painful in nature. Frequently the underlying arthritis is asymptomatic and normal in amount for a particular age group. Several diagnoses are responsible for neck and low back pain. To term all of the patients as having lumbar or cervical osteoarthritis is not correct.

The parameters for judging success are vague. For example, improvement in motion is difficult to ascertain in many instances because of the underlying apprehension and guarding exhibited by many of these patients. Ranges of motion in the low back and neck may vary in these patients by several degrees in the event the examiner checked these motions on more than one occasion during a single office visit.

The decrease in dosage and frequency in medication is likewise nebulous as the correct medications and dosages are presupposed by him to be correct. The L-C neurometer measures skin resis-

tance and has been found to be lacking in accuracy by many acupuncturists. Perhaps the most precise measurement of improvement demonstrated in the paper is the opinion of the patient that he has improved.

Unfortunately this study proved nothing to me. Dr. Matsumoto states that no one was rendered worse. In his series of 500 patients no complications are reported. Yet he cites control in a medical school atmosphere "because the safety of the patient must be the primary concern." Acupuncturists tell us that the procedure is totally safe and simple. The executive director of the National Acupuncture Research Society, Dr. Frank Warren of New York City, stated at the recent Hahnemann symposium on pain and acupuncture that acupuncture could be learned by a physician literally within minutes.

Data of the kind presented in this paper will offer the practicing physician false hopes. Rather, the proper course of investigation of the efficacy of acupuncture in our state is for several physicians of all specialities to work out protocols for use in specific disorders in their field. They should then perform acupuncture on patients whom they have followed for long periods of time and with whom they have failed for one reason or other to gain a satisfactory response to conventional therapy. In this way the skeptical medical community would amass substantial data within a reasonable period of time. Acupuncture is by and large an office procedure. Confining its use to a medical school setting is unnecessary and needlessly prolongs determination of its worth.

Thousands of citizens of Pennsylvania are flocking in and out of the state for acupuncture. The medical community should be in the forefront of education and relief in this matter. Failure to proceed quickly with the massive in-depth clinical investigation as outlined above only allows the seamier, untrained element to capitalize on the unwary public.

J. Joseph Danyo, M.D.
York

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book review

MEDICAL GENETICS. Edited by Victor A. McKusick, M.D., and Robert Claiborne. New York: H.P. Publishing Company, 1973. 300 pages, illustrated. $13.95

A collection of a series of articles published in *Hospital Practice* from 1969 to 1973, this book was written by thirty-three authors. Beginning with a short introduction by the editor in which he dispels some misconceptions commonly associated with genetics, the remainder of the text is divided into six sections. The material is organized so that the reader is reintroduced to genetic laws and mechanisms of genetic abnormalities prior to discussion of the more complicated modes of inheritance and syndromes.

Section 1 deals with the chromosome and its disorders. Genetic descriptions and physical manifestations of syndromes such as Klinefelter's are presented and well-illustrated.

Section 2, "Basic Biochemical Genetics," deals with enzyme defects, vitamin-dependent genetic disease and hemoglobinopathies. Of particular interest was the chapter on pharmacogenetics. Several of the more common drugs (isoniazid, coumarin, and some anesthetic agents) are used in an attempt to explain an individual's varying reactions to the drug.

Section 3 titled "Specific Biochemical Disorders" deals with entities such as porphyria, mucopolysaccharidoses, and defects of growth hormone. Section 4 discusses immunogenetics.

Section 5, "Multifactorial Genetic Disease," deals with those anomalies that are said to "run in families." Cleft lip, diabetes, and schizophrenia are notable examples.

Section 6, "Clinical Applications of Genetic Knowledge," is clearly the most useful to the practicing physician. It is made up of eight chapters, the most interesting and applicable of which are prenatal detection of hereditary defects and genetic counseling. Amniocentesis has made it increasingly possible to discover fetal diseases. Some diagnoses are being made early enough to permit therapeutic abortion, as in Tay-Sachs disease, or to prepare for treatment of the child. Genetic counseling is an important part of medical practice. Once a diagnosis is established, of hemophilia for example, parents often want to know what the possibility is for birth of another child with the same condition. The physician should be prepared to advise or refer to a genetic counselor.

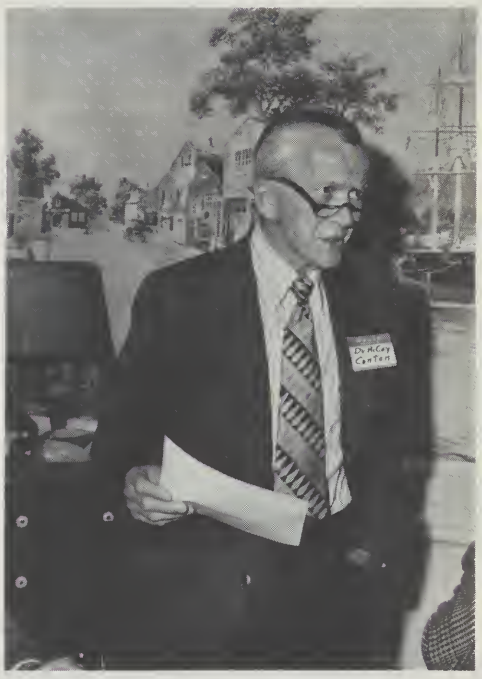
Some chapters of the book are more readable than others owing to the multiple authorship. No chapter, however, is poorly done. All are well-illustrated. References and index appear at the end of the book and are adequate.

David A. Smith, M.D.
Medical Editor

rotogravure

STATE SOCIETY *activities set a new pace during the past month, as members dealt with issues facing medicine in a myriad of meetings throughout the state. The 1974 Officers' Conference broke attendance records and provided an opportunity for councils and committees to meet both before and after the session. Shown here and on the following pages are the camera's views of the Society at work.*

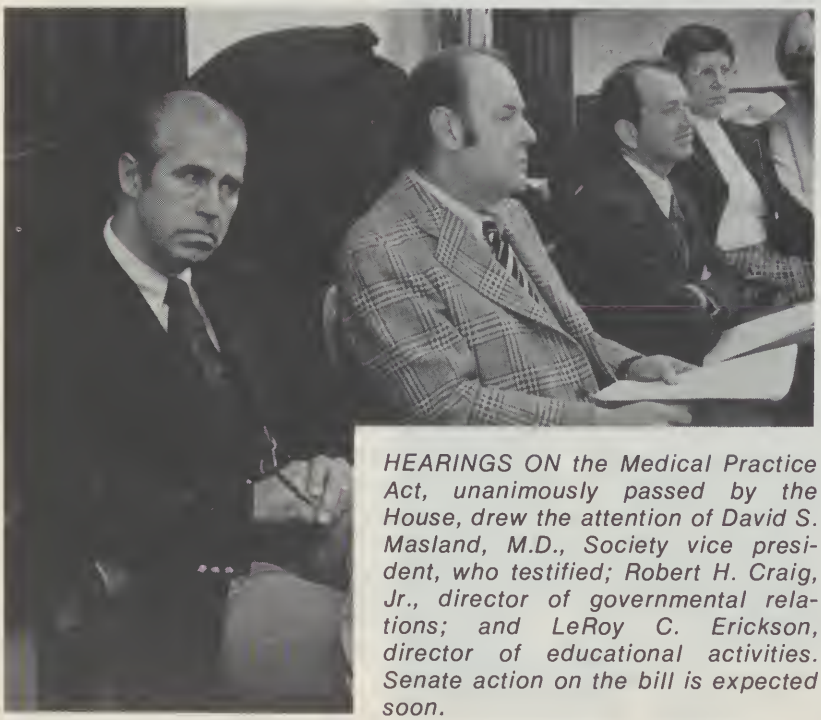
THE THIRD AND TWELFTH COUNCILOR DISTRICTS joined forces at Pocono Manor Inn on May 11 to discuss Society business under the joint chairmanship of Orlo G. McCoy, M.D., Canton, trustee for the Twelfth District, and Ralph K. Shields, M.D., Bethlehem, Third District trustee. Ralph C. Wilde, M.D., Society president, joined a group of State Society staff members to brief physicians on legislative activities, the Foundation, the Pennsylvania Medical Cooperative, and the Society's continuing education requirement.



GOVERNOR MILTON J. SHAPP declared May as High Blood Pressure Month and was observed by three physicians as he signed the proclamation April 30. Looking on, left to right, are Raymond C. Grandon, M.D., trustee of the State Society, Lee H. Shields, M.D., Harrisburg, who represented the Pennsylvania Affiliate, American Heart Association, and Secretary of Health J. Finton Speller, M.D. This magazine's July issue will feature the latest in hypertension information for physicians.

STUDENTS from Pennsylvania Sta University and Juniata College e tering medical school this fall we honored by the Sixth Councilor D trict at a dinner meeting May Students heard Ralph C. Wilde, M. Society president, speak at this se enth annual event arranged by Thompson Dale, M.D., trustee for t Sixth District. Shown here, left right, are Dr. Dale, Dr. Wilde, Pa Wengrovitz, M.D., president of t Centre County Medical Socie Wesley D. Thompson, M.D., pa president of the Mifflin-Juniata So ety; Joseph Stowell, M.D., past pre dent of the Blair Society; and Rob Boron, president of the Clearfield S ciety.

Dr. Fister presents views



HEARINGS ON the Medical Practice Act, unanimously passed by the House, drew the attention of David S. Masland, M.D., Society vice president, who testified; Robert H. Craig, Jr., director of governmental relations; and LeRoy C. Erickson, director of educational activities. Senate action on the bill is expected soon.

Dr. Robertson reports

TWO FATHER-SON TEAMS received special attention at the dinner, which attracted 100 physicians and students. Shown left to right are Ralph Pilgrim, M.D., student health services physician at PSU; his son, Paul; Douglas Mayers; and his father Stanley A. Mayers, M.D., professor in the College of Human Development at Penn State.

Giving reports are Larry R. Fosselman, above, and David H. Small, below

MALPRACTICE loss prevention was the subject of a seminar at the annual meeting of the Pennsylvania Society of Anesthesiologists held May 10-12 at Seven Springs Resort, Champion. Shown above, left to right, are A. John Smither, vice president of Frank B. Hall and Co. of Pennsylvania, administrator of the Society's professional liability insurance program, and Eli P. Bernzweig, J.D., vice president of Argonaut Insurance Co., the program's underwriter. Dr. Bernzweig arranged the educational seminar.

Panelists at Officers' Conference

Foundation meeting at Officers' Conference

SHOULD YOU JOIN A UNION? This was the question debated at a recent Blair County Medical Society meeting in Altoona by William Y. Rial, M.D., of Swarthmore, vice speaker of the AMA House of Delegates, and Stanley S. Petersen, M.D., of Springfield, Mo., president of the American Federation of Physicians and Dentists. Dr. Rial, right, said physicians are reacting to the erosion of traditional individualism and pressures caused by increasing government regulations, which they feel will adversely affect the physician patient relationship. But he said unionization cannot provide answers for physicians as well as the AMA, and pointed out that the AMA structure permits the county and state medical societies to function freely, while organized labor sets policy nationally controlling local units. Dr. Petersen, left, told physicians he supports the AMA as a delegate, but said physicians need a decision making and action taking body which expects compliance with majority decisions. Government control, he said, makes such organized activity necessary.

John F. Rineman reports

First District meets

Dr. Zamostien speaks

Tenth District meets

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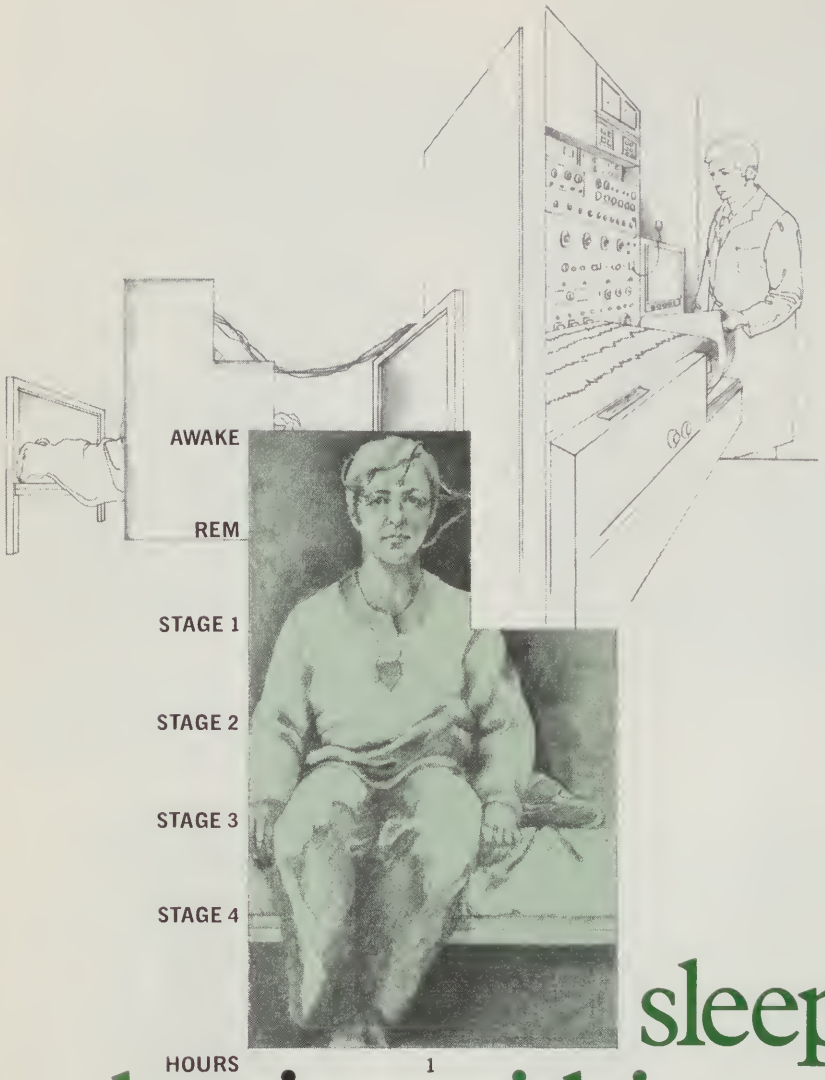

sleep begins within 17 minutes, on average ...

an initial benefit of

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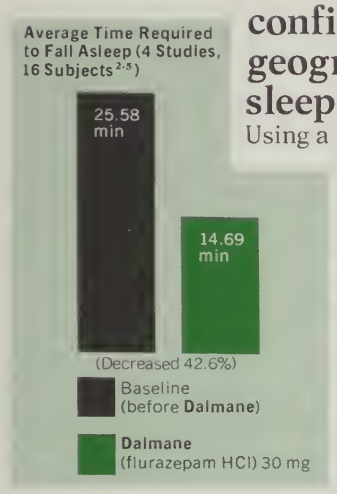
proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

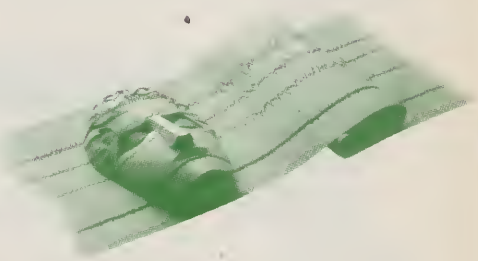
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it, for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

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Joseph F. Sadusk, Jr., M.D.
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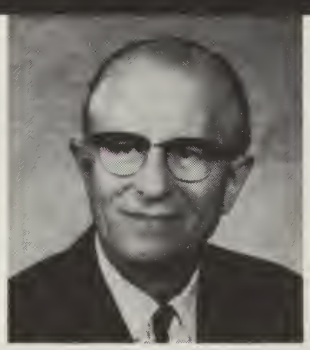

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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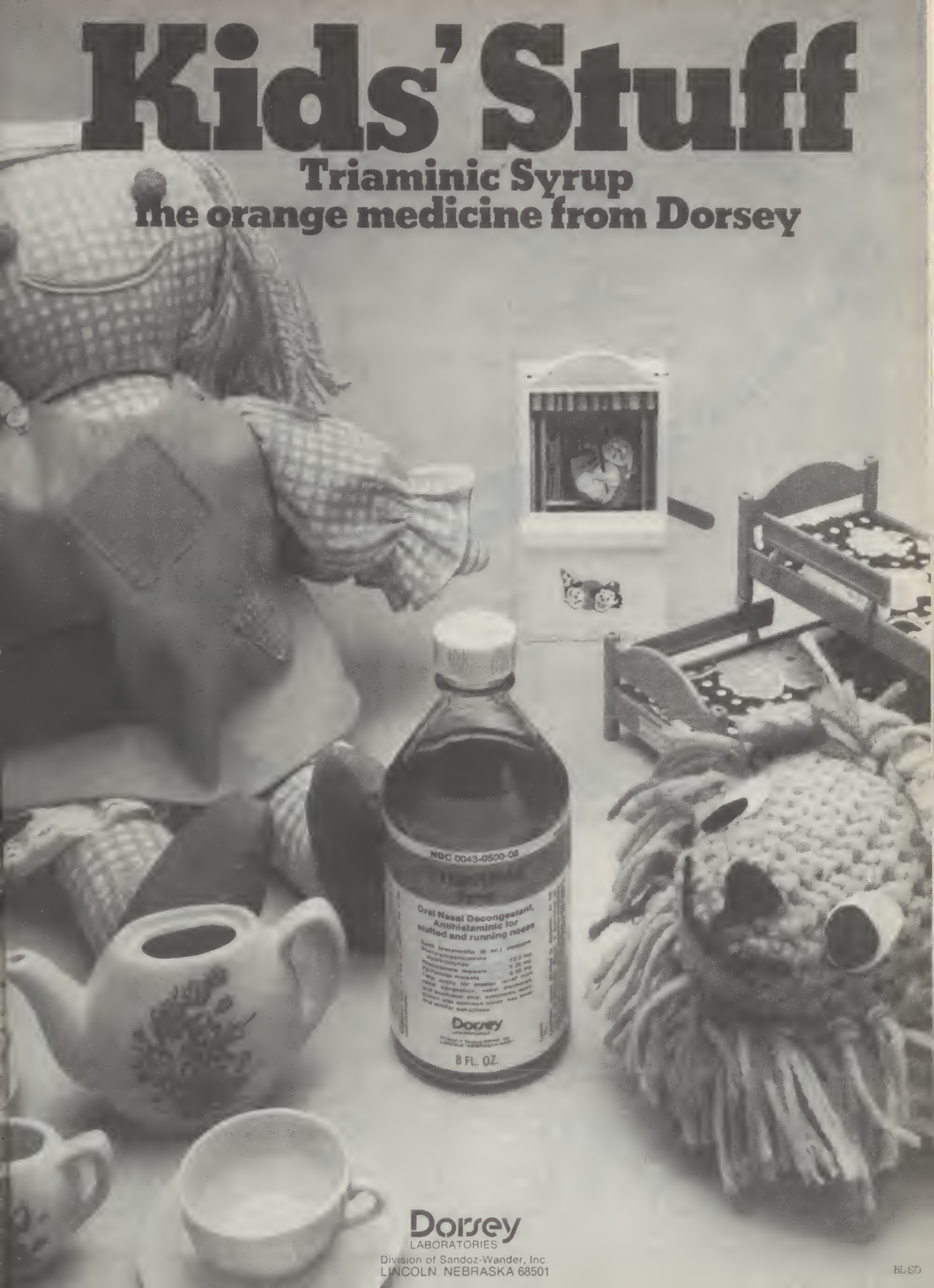
the orange medicine from Dorsey



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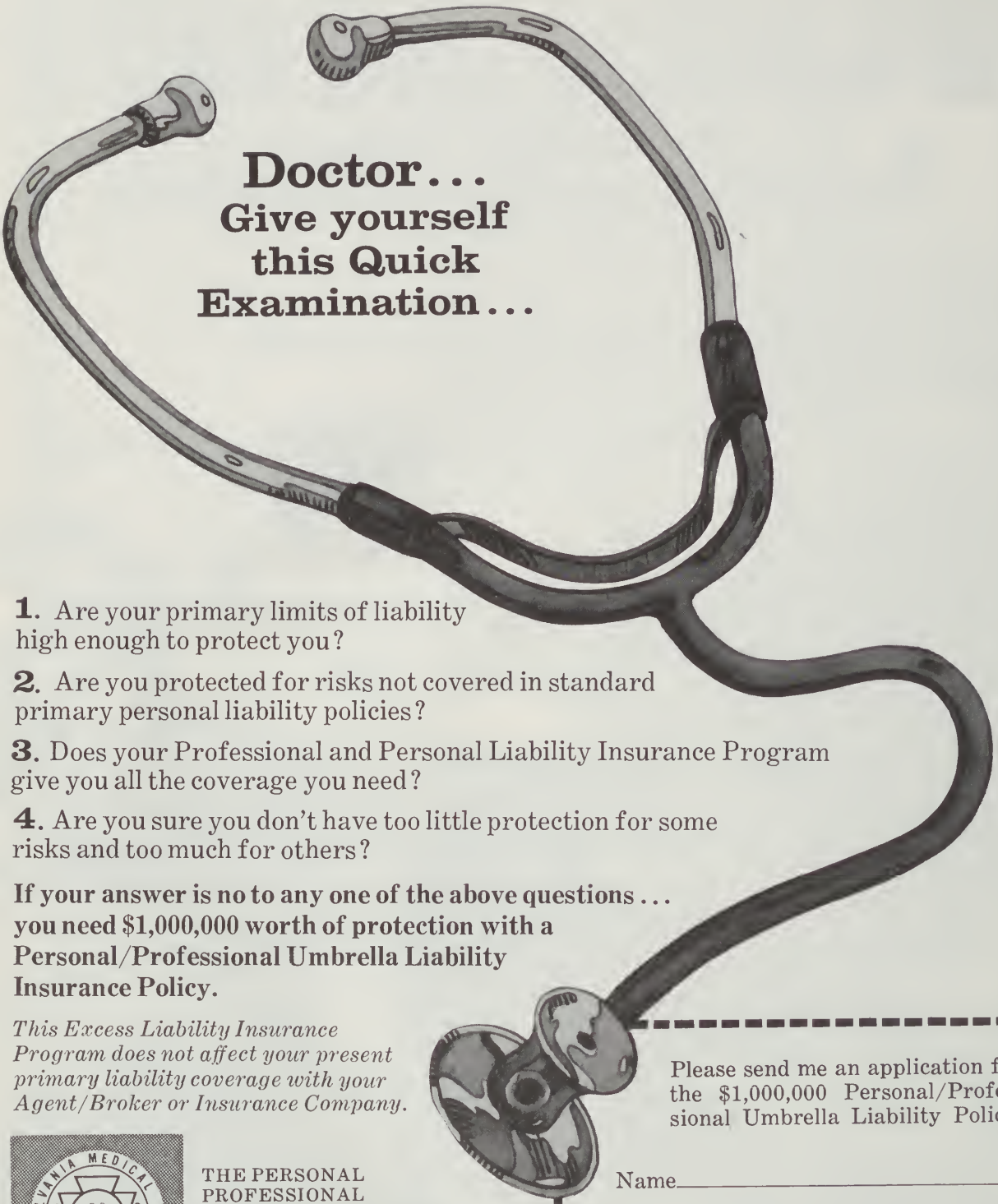

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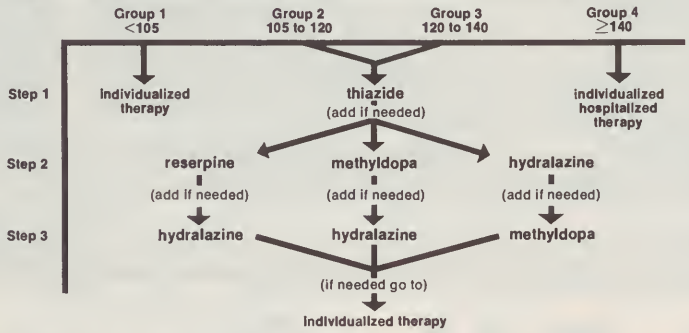
Outline of Recommended Antihypertensive Regimens for Groups with Varyingly Severe Hypertension as Indicated by Diastolic Pressure (in mm Hg)



Therapeutic Objective: Diastolic Pressure under 90 mm Hg, or, if untoward effects cannot be tolerated, under 100 mm Hg.

"All hypertensives should have treatment for any lipid disorder and obesity and should be instructed to stop smoking cigarettes and to engage in appropriate regular exercise." Report of Inter-Society Commission for Heart Disease Resources, Circ. Vol. XLIV, Nov. 1971.

Adapted from National Blood Pressure Education Program, Task Force I, Sept. 1973.

A

Basic Dosage and Time Recommendations for Antihypertensive Regimens

DRUG DOSAGE*	Group 2 Diastolic pressure 105 to 120 mm Hg		Group 3 Diastolic pressure 120 to 140 mm Hg	
	Initial dose (mg/day)	Maximum dose (mg/day)	Initial dose (mg/day)	Maximum dose (mg/day)
Diuretics	(Begin with half dose and increase in one step to full dose if needed)		(Begin with full dose)	
Reserpine	0.1	0.25	0.1	0.25
Methyldopa	500	2000	750	3000
Hydralazine	30	200	75	300
Time interval	**Average Interval (months)**	**Maximum interval (months)**	**Average interval (months)**	**Maximum Interval (months)**
Interval between visits while BP is being lowered	½	2	¼	1
Interval between visits when BP is under control	2	4	2	4
Interval between re-examinations and repeat lab work	6	12	6	12

*Diuretics and reserpine can be given in single daily doses. Methyldopa and hydralazine should be given in 2 to 4 divided doses.

For complete information on action, side effects, and contraindications of antihypertensive drugs, see "Hypertension: Drug Treatment" 1973 and "Hypertension: Office Evaluation" 1972, American Heart Association.

AMERICAN HEART ASSOCIATION • 44 East 23 Street, New York, N.Y. 10010

EM633 PE 1-74-25M

Available Oral Diuretics

	Full Dose (mg/day)
A. SULFONAMIDE DERIVATIVE DIURETICS	
Thiazides	
Chlorothiazide	1000
Flumethiazide	1000
Hydrogenated Derivatives	
Hydrochlorothiazide	100
Hydroflumethiazide	100
Substituted Compounds	
Bendroflumethiazide	5
Benzthiazide	100
Trichlormethiazide	4
Methyclothiazide	5
Polythiazide	8
Cyclothiazide	2
Chlorthalidone	100
Quinethazone	100
B. POTASSIUM-SPARING DIURETICS	
Spironolactone	100
Triamterene	300
C. NON-SULFONAMIDE DIURETIC AGENTS — Most potent oral diuretics, but more liable to induce side effects than milder agents	
Furosemide	80
Ethacrynic acid	100

Antihypertensive Drug Data

	Usual daily dose (mg) Initial	Maximal
A. RAUWOLFIA ALKALOIDS		
Rauwolfia (whole root)	100.0	200.0
Alseroxylon	1.0	2.0
Reserpine	0.1	0.25
Deserpidine	0.25	0.25
Rescinnamine	0.25	2.0
Syrosingopine	1.0	3.0
B. METHYLDOPA	500.0	3000.0
C. HYDRALAZINE	50.0	300.0
D. GUANETHIDINE	12.5	No limit
E. GANGLION BLOCKING AGENTS		
Mecamylamine	2.5	No limit
Pentolinium	2.5	No limit

The above "Outline of Recommended Antihypertensive Regimens" is available in a larger card form, free from the Heart Association. For your personal copy, contact your local Heart Chapter or write: American Heart Association, Pennsylvania Affiliate, P.O. Box 2435, Harrisburg, Pennsylvania 17105.

Also ask about the Affiliate's Scientific Session to be held September 27-28 at the Hershey Motor Lodge, Hershey. AMA/PMS Category I credit will be given.

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1974 PHYSICIAN'S RECOGNITION AWARD application forms will not be available until late summer. 1975 applications will not be available until next spring. In the interim, special record forms and file folders for collecting data are available from:

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Pennsylvania Medical Society
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Continuing Medical Education AWARD

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M.D.s in the news

David C. Scicchitano, M.D., Mount Carmel, has been honored as citizen of the year by the Mount Carmel American Legion. He is a past president and is currently secretary of the Northumberland County Medical Society.

Geisinger Medical Center has announced the appointment of two associates to the department of anesthesiology. **F. Shihata, M.D., and M.H. Kulkarni, M.D.,** both completed their anesthesiology residency at New York Hospital and Cornell University. They are both members of the American Society of Anesthesiologists.

Wendell B. Garren, M.D., formerly physician senior grade, department of psychiatry at the Veterans Administration Hospital in Lebanon, has become an associate in the department of community medicine at Geisinger Medical Center, Danville.

Jonathan E. Rhoads, M.D., and Harold G. Scheie, M.D., both of Philadelphia, have received two of the ten 1974 *Modern Medicine* awards for distinguished achievement.

Children's Hospital of Philadelphia reports that **Lester Baker, M.D.,** director of the clinical research center, participated in a symposium sponsored by *Excerpta Medica* in May. **William J. Rashkind, M.D.,** director of the cardiovascular laboratories, addressed the Association of European Pediatrics Cardiology in London and the Gesselsdraft fur Pediatrics in East Berlin recently.

Herbert Kean, M.D., Philadelphia, assistant professor of otolaryngology at Jefferson Medical College, Thomas Jefferson University, moderated a panel discussion and delivered a paper on submental lipectomy at the American Academy of Facial Plastic and Reconstructive Surgery scientific meeting in Palm Beach, Florida, recently. Dr. Kean is assistant attending physician in otolaryngology at Thomas Jefferson Hospital and assistant surgeon at Children's Hospital of Philadelphia.

John F. Ditunno, Jr., M.D., Philadelphia, has been elected president of the Association of Academic Physiatrists. He is professor and chairman of the department of rehabilitation medicine at Jefferson Medical College of Thomas Jefferson University. He is also a member of the American Board of Physical Medicine and Rehabilitation and serves as chairman of the continuing education committee of the American Academy of Physical Medicine and Rehabilitation.

Bernard Fisher, M.D., Pittsburgh, professor of surgery at the University of Pittsburgh School of Medicine, has been appointed to the newly created post of director of the health center's cancer program and director of cancer programs of the university's school of medicine. He is a member of the Commission on Cancer of the American College of Surgeons, the planning committee of the International Cancer Congress, and the National Cancer Institute's Treatment Advisory Committee.

Herbert Diamond, M.D., Philadelphia, who was recently named director elect of Region III of the National Council of Community Centers, recently coauthored a paper on community health centers which was presented at the First Provincial Conference of the Alberta Mental Health Services in Edmonton, Canada. Dr. Diamond is assistant clinical professor of psychiatry and medical director of the West Philadelphia Community Mental Health Consortium.

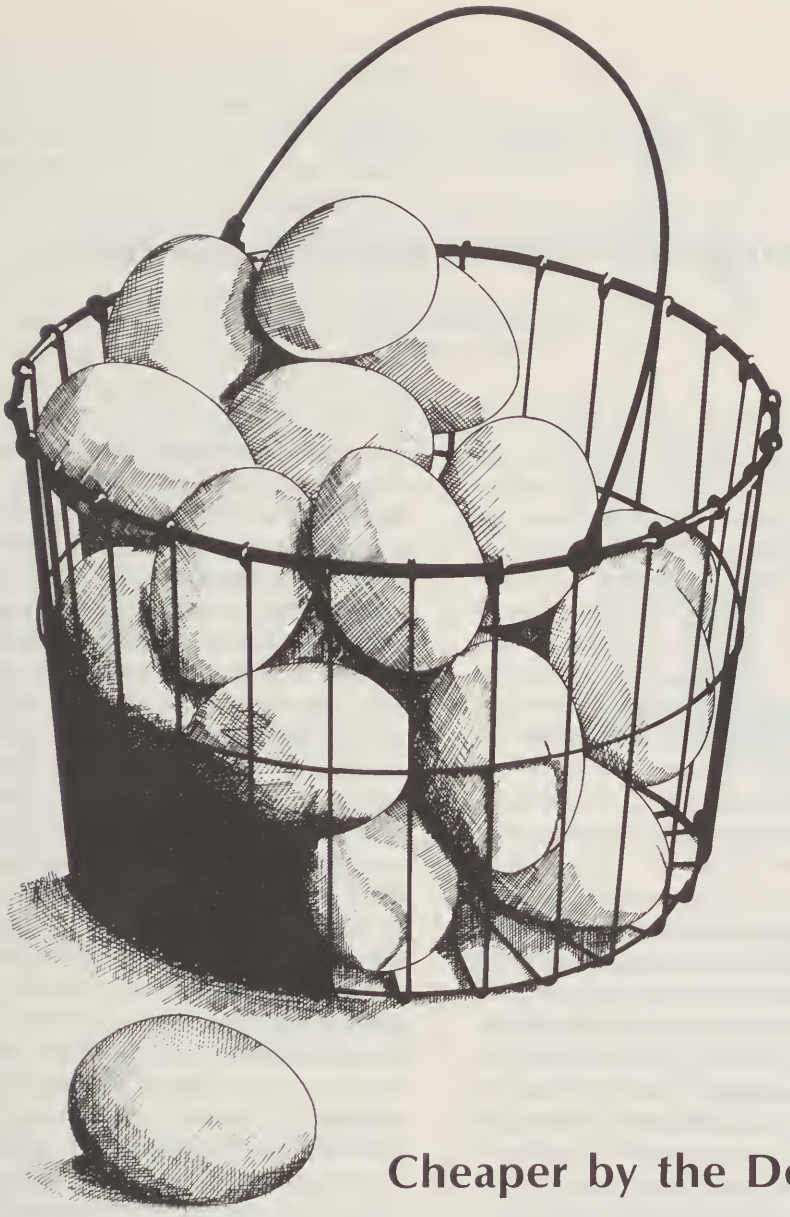
L. M. Hoffman, M.D., Williamsport, has published a book "Reflections of a Country Boy." It may be obtained from Hilsher Graphics.

Norman J. Winston, M.D., Reading, has been named a fellow of the American College of Radiology. He is in private practice in Reading and is affiliated with Jefferson Medical College of Thomas Jefferson University.

Alan J. Oram, M.D., former flight surgeon at the U.S. Naval Air Station in Meridian, Miss., has joined the staff at Geisinger Medical Center, Danville, in the emergency room service. **Gary L. Wolfgang, M.D.,** former physician in the emergency room at Holy Spirit Hospital, Camp Hill, has been appointed to the Geisinger medical staff in the department of orthopedics.

Meyer Sonneborn, M.D., Wind Ridge, has been honored by the Greene County Chapter of the American Red Cross for his service as staff physician for county bloodmobiles. He also was presented with a three-gallon donor pin.

WILBUR E. FLANNERY, M.D., (right) receives congratulations on the occasion of his election as chairman of the Pennsylvania Blue Shield Board of Directors from Allen W. Cowley, M.D., outgoing chairman, who declined reelection. Dr. Flannery, New Castle internist and past president of the Pennsylvania Medical Society and the Lawrence County Medical Society, currently serves the Society as a Pennsylvania delegate to the American Medical Association.



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Membership in the Cooperative will be open to Pennsylvania Medical Society members only. The only cost is a nominal $100 once-and-done lifetime membership fee, all or a substantial part of which will be returned if you should decide to withdraw. In all probability you will save more than the amount of the membership fee in your first-year purchases alone.

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Another New Benefit to Members of Pennsylvania Medical Society

Facing medicine's gravest problem

LEIF C. BECK, LL.B.
Bala Cynwyd

In the last two months' articles, I have described the "Health Maintenance Organization Act of 1973," including the threats and opportunities which HMOs present to private practice. As an attorney and as a medical management consultant, I am an advocate of the private practice of medicine, but I also am convinced that the overall threat to such practice is due to its poor public image. And while most individual practitioners seem really to be providing excellent medical care, they are at the same time much to blame for the public image problem. Hence, if HMOs develop still more public support, the hard-working, self-sacrificing, private practitioners might have to blame only their collective selves.

My friend and colleague on the recent Pennsylvania Medical Society Practice Management Seminar, Thomas E. Zirkle, wrote on this subject some five years ago in an article in the September 1969 *Journal of the American Osteopathic Association*. Much of what he said continues to be so appropriate that I wish to reproduce major parts below. His observations parallel mine as they have developed from countless practice surveys and interviews with clients' aides. You too may recognize the situation in either your own or colleagues' practices, for each individual practice with these public relations defects is another nail in private practice's coffin.

The rest of this article exerpts from Mr. Zirkle, with some omissions. The portions in italics are my comments.

> I consider the deplorable state of its public relations the medical profession's gravest problem. The great majority of my consulting colleagues agree that adverse public relations is the severest problem confronting medicine and that the existing situation is very serious indeed. In making this assessment, I wish to make it plain that this difficulty is not an institutional one or one in which the disaffected are limited to certain segments of the government or the press.
>
> *The disenchantment is widespread and on a very personal basis—right at the patient-doctor level.* Many patients genuinely believe that they are frequently the victims of indifference, incompetence, or economic exploitation in their relationship with their physician. Whether they are right or wrong is immaterial; it is their conviction that matters.
>
> In attempting to deal with this situation, one of the most formidable obstacles is the reluctance of physicians to acknowledge the existence of the problem. It is important here, incidentally, to differentiate between the existence of the general public's attitude and the validity of its beliefs. What people believe to be true and what is true may be entirely different. I am convinced that this is the case, particularly regarding charges of widespread incompetence and economic exploitation. *Nevertheless, the indictment exists and will become increasingly prevalent unless the individual physician recognizes the problem and takes action to come to grips with it.*
>
> Interestingly enough, very few physicians make any correlation between poor public relations and the ominous trend of the government to intervene in private medicine. When the possibility of such a relationship is suggested, most doctors express firm disbelief and attribute legislation on medical care to the persistent efforts of a few professional liberals. While such an element obviously exists and has had considerable influence in Congress, the simple truth of the matter is that most members of Congress voted for these measures because their constituents wanted them. While this may be a difficult concept to accept—and I know that many cynics will describe it as naive—I would venture to guess that a public referendum on Na-

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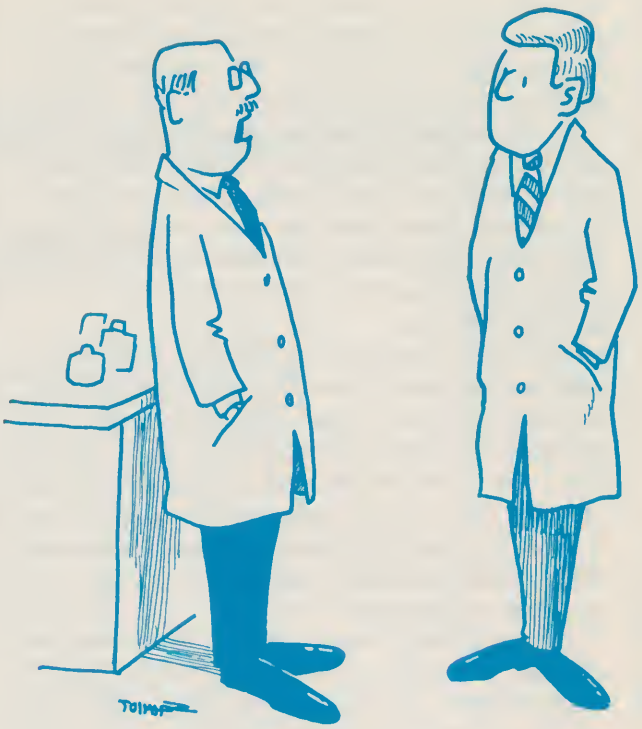
tional Health Insurance at this time would find overwhelming public support for the program with perhaps a large footnote condemning the professions for the many well-publicized abuses which have appeared in the press.

You may disagree with this conclusion; *yet it seems inevitable to me that government intervention in medicine will directly and accurately reflect the state of discontent between doctor and patient.* If this discontent is neutralized or abated, private practice will not only survive but will flourish. If it continues to deteriorate, private practice as we know it now will be only a memory in a few short years. This is the challenge today; the issue is squarely before your profession and it is a personal issue, not an institutional one. The American Osteopathic Association, the American Medical Association, the American Dental Association, or any other professional organization, is powerless to substantially influence the outcome of this issue.

The real solution is almost totally in the hands of you, the private doctor, as you deal with your patients on a person-to-person basis.

What is the solution to your public relations dilemma? To get at this question, it is first necessary to determine why a very substantial element of the public is actively at odds with the medical profession. The answer to this question, I believe, is threefold: (1) Ignorance on the part of the patient; (2) indifference, or the appearance of indifference, toward the patient by the physician or his aides; and (3) the irresponsible or unscrupulous actions of a small minority whose well-publicized activities have cast a shadow of suspicion over all practitioners.

Patient ignorance is most often manifested—and is most harmful—in an almost total inability to distinguish good medical practice from bad. In point of fact, the great majority of patients simply do not have adequate technical knowledge to make a reasonable evaluation of the quality of care they receive. This is not a criticism of the health care consumer; rather, it is an acknowledgement that the medical field is so broad and complex that it would be unreasonable to expect the average patient to possess sufficient knowledge for rational evaluation of the services they receive. Nevertheless, they almost always do develop an opinion regarding their medical services. These



I had an unusual experience today—I talked with a detail man.

opinions are influenced primarily by peripheral elements such as the personality, attitude, and appearance of the doctor and his aides; the appearance and comfort of the doctor's office environment; the degree of personal inconvenience experienced; fees, etc.—not by the quality of actual medical service they receive.

Naturally enough, most doctors resist acceptance of this theory because they would prefer to be judged solely on their professional competence—substance rather than image. *However, judgment primarily on the basis of professional competence is not widespread now, and it is not probable in the foreseeable future.*

The unwillingness of the medical profession to accept this principle has prevented it from recognizing the need for selling the quality and value of its services to the public. This is exemplified by the doctor who, when exposed to my observations on the subject, replied, "I spend sixty to seventy hours a week providing good and necessary medicine, and I have a hard time keeping my head above water. Why should I spend additional time and effort convincing my patients that they are receiving good service at reasonable cost?" The answer is that—for the sake

of the medical profession—*the patient should not only receive good service but must be convincingly aware that he has received good service at reasonable cost, even if that requires some sales effort on the part of the doctor*. The effort required is not of the hard-sell variety and really does not require additional time. It requires only a continuing effort to provide the patient with maximum comfort, convenience, and thoughtfulness in his relationship with you.

The most common complaint I hear from medical patients is that they are received and treated with almost total indifference and detachment by the doctor and his staff. They must often wait for an unconscionable time to see the doctor, frequently are allocated too little of the doctor's time, and very often feel that answers or explanations by the doctor, if any, are inadequate.

Unfortunately, there is often a considerable element of truth in these complaints, which leads directly to the patient's conclusion that he is not really important to the doctor and his staff. Nothing, I might add, could be better calculated to arouse the fury and resentment of a patient and to destroy any chance of developing a mutually respectful and successful relationship between the parties.

I am aware that some of these problems are often virtually insoluble. For example: total patient demands curtail the time which can be spent with individual patients, and some medical problems defy adequate explanation. However, I also know of my own knowledge that many of these accusations are true and are preventable. For example: I know for a fact that many doctors do not really care how long a patient waits beyond his appointment. Deep down, they believe that their own time is more valuable and important than that of the patient and this belief is often communicated quite emphatically to the patient.

The fact of the matter is that time has become a more precious commodity for virtually everybody in recent years, and any busy person will harbor an active grudge against those who unnecessarily waste his time. The resentment will mount proportionately if the time is wasted in a crowded, uncomfortable office manned by cold or inconsiderate aides. How would you react if you visited an advisor (such as a lawyer or accountant), waited two hours in his dingy reception room, spent ten minutes with him, received inconclusive advice, and then received a substantial bill in the mail?

The answer is obvious, as is the moral. While you cannot spend unlimited time with a patient, and while you cannot solve or explain every medical problem, you can provide a comfortable office environment, and you can see to it that your aides are helpful and hospitable. You not only can, but you must—if you and your profession are to avoid the fatal label of indifference.

In recent months the phrase ". . .must not be guilty of impropriety or the appearance of impropriety" has received considerable prominence. I believe that this canon is equally applicable to the medical profession. After all, a healthy doctor-patient relationship must be cast in a foundation of confidence and trust, and the patient particularly must have unequivocal confidence that his doctor is acting in his best interest at all times, which specifically includes economic as well as health interests.

The statement has been made to the effect that "nothing is wrong with medicine that a little competition wouldn't cure," and I partially subscribe to that statement. The intendment of that observation is that if the supply of doctors available was large enough or larger than necessary to meet public demand, the public would get a better shake in terms of service and attention. This is probably true; *it is certainly true that the members of the profession confronted with the necessity of competing for patients would pay substantially more attention to the state of their public relations*. This would inevitably benefit the patient in terms of comfort, convenience, and personal attention.

Nevertheless, as a matter of realism, genuine competition simply is not likely to materialize in the near future. *Consequently, the profession—on an individual and collective basis—must stimulate itself through self-discipline to establish the same standard of conduct as would exist in the presence of real competition*. This is admittedly a difficult proposition, and I have to acknowledge that few disciplines would be successful in achieving this particular form of self-regulation. Nevertheless, the effort must be made or external regulation will inevitably result. It is in this way that the fears of many medical men concerning total government intervention will become a reality.

Transferring patients with brain injury safely

WILLIAM F. BOUZARTH, M.D.
Philadelphia

With the current emphasis on categorization of hospitals and establishment of trauma centers, interhospital transfer of seriously injured patients is becoming a reality. The concept of taking patients "to the nearest hospital" is now under attack. In Maryland last year over 1,000 seriously injured accident victims were transported by helicopters from the scene to their trauma hospital. In the last six years, 160 patients with severe head or spine injuries have been transferred to the Episcopal Hospital Head Injury Center from Philadelphia area hospitals. Only one death occurred en route, and recently a patient was resuscitated in transit, only to die soon after arrival. The following guidelines are suggested for consideration prior to interhospital transfer of patients with brain injury.

Airway—No unconscious patient should be transferred unless he has an adequate airway. Provided there is no cervical spine injury (see below), endotracheal intubation is advised. The cuff should be inflated just before leaving and the time noted on the adhesive tape which secures the tube around a bite block and the face. More responsive patients will not tolerate an endotracheal tube, so that a nasopharyngeal airway and/or the semiprone position is preferable (Fig. 1).

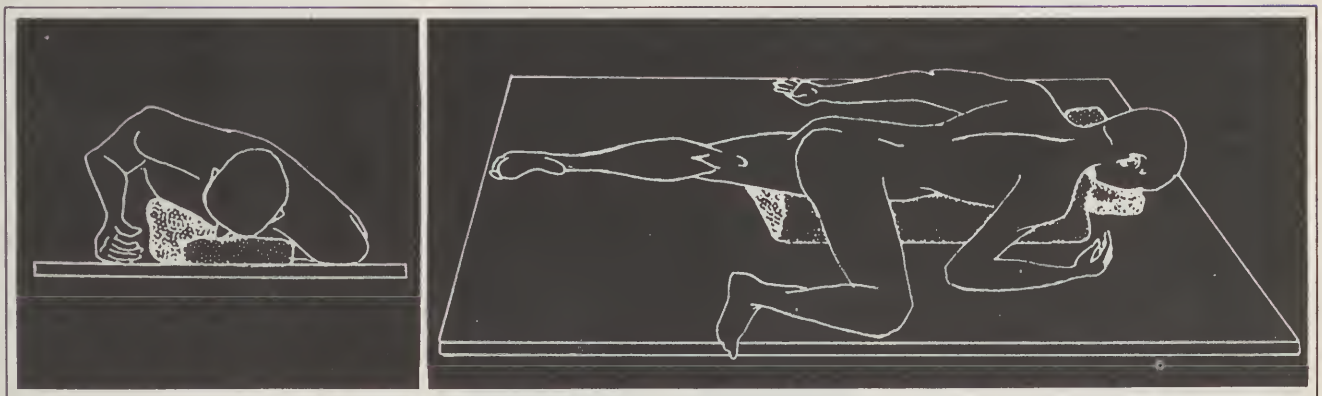


Figure 1. Semiprone position for unconscious patients.

Dr. Bouzarth is on the staff of the department of neurological surgery at Episcopal Hospital, Philadelphia. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information concerning trauma.

Bleeding—Considerable blood may be lost at the scene from scalp laceration despite the fact that bleeding can usually be controlled by pressure dressings. If not, hemostats clamped over the galea and reflected over the scalp usually will stop bleeding (Fig. 2). Self-retaining retractors can be used to spread the wound taut for hemostasis in the unconscious patient. Regardless of the method, a sterile dressing is then applied.

Figure 2.

Cervical spine injury—If a patient does not require cardiorespiratory resuscitation when first examined, a cross table lateral x-ray film of the cervical spine is required. The shoulders should be depressed toward the feet so as to visualize all seven cervical vertebrae. If a fracture is revealed and/or the neurologic examination suggests spine injury, airway support becomes more (rather than less) important in the unconscious victim. Endotracheal intubation by the blind nasal approach or passing the tube over a flexible fiberoptic bronchoscope is suggested; otherwise consider tracheostomy. Then the patient can be securely fastened to a spine board. (A conscious para or quadriplegic patient, even with adequate diaphragmatic breathing, requires gastric aspiration prior to movement.)

Drugs—Intravenous fluids should be administered slowly (0.5 ml/minute) as 2½ percent glucose in one-half normal saline unless hypovolemic shock is suspected or actually exists. The intracath should not cross major joints but should be large enough for blood transfusion. Drugs should *not* be injected through a central venous pressure line. For prophylactic anticonvulsive therapy, 250 mg of diphenylhydantoid (Dilantin® Parke, Davis & Co.) should be administered intravenously at the rate of 50 mg per minute every thirty minutes until 1000 mg has been injected while vital signs are being monitored. This regimen is contraindicated in the elderly or patients with heart disease.

Should convulsions occur, 10 percent aquaeous sodium amobarbital (Amytal® Eli Lilly & Co.) may be administered at a rate of one ml per minute until 10 ml are given or the convulsions have stopped. Apnea is not likely to occur. Hyperosmolar solutions such as 20 percent Mannitol® (Abbott Laboratories) tend to dehydrate the brain producing a diuresis (see Foley), and cerebral blood flow is increased, magnifying any potential intracranial hemorrhage. Other than to buy time for a rapidly deteriorating patient, osmotic diuretics should be given only at the request of the neurosurgeon who is to receive that patient.

Examination—Broad descriptive terms such as semicoma or stupor should not be used; rather, a simple check-off neurosurgical watch sheet developed at Episcopal Hospital is suggested. Of course, a legible copy of the emergency department record, laboratory tests, and all x-rays should go with the patient. Skull or long bone x-rays usually are not important in the early examination of the patient.

Foley Catheter and Fractures—Indwelling catheters are recommended especially if hyperosmolar solutions are given. Obvious fractures should be immobilized.

Gastric Aspiration—A nasogastric tube for gastric aspiration is important unless a cuff endotracheal or tracheostomy tube has been inserted. It is especially important when a patient is to be transported supine because of other injuries.

Hypovolemic Shock—Shock is a contraindication to transportation. Even without signs of shock, one unit of blood should be sent with the patient for every fifteen minutes of travel time.

Informed Consent—Relatives should be informed that transfer is necessary, that death can occur en route, and that those at the neurosurgical trauma hospital may not recommend surgery. Such a consent form has been developed (Fig. 3).

SPECIAL PERMIT TO BE SENT WITH PATIENT

I understand that _____ is in critical condition and is being transferred to _____ Hospital for emergency neurosurgical care. I give permission, as the closest relative who is immediately available, for the _____ Hospital staff to proceed with whatever tests or treatment they consider necessary, including emergency brain or spine surgery.

I also agree to come to _____ Hospital or to help get other relatives (who may be closer to the patient) there as soon as possible.

I realize that the patient is in critical condition and may not live to reach _____ Hospital, or that when he or she arrives, the medical findings may be such that emergency surgery is not in the patient's best interests.

_____ _____

Date Signature

_____ _____

Witness Relationship

Figure 3. Special consent form.

Justifiable Vehicular Speed—Remind the driver that you want *all* to arrive safely and instruct him to obey the law.

Treatment of children without parental consent

ALAN MEISEL, J.D.
Pittsburgh

IN Pennsylvania any person who has not yet attained the age of twenty-one is considered a minor—the technical legal term is "infant"—and, as a consequence, suffers some legal disabilities. While the Twenty-Sixth amendment to the United States Constitution in 1971 granted the right to vote to all persons age eighteen or older, persons under age twenty-one are still treated as minors in Pennsylvania for other purposes, including the right to purchase alcoholic beverages or to hold some elective offices. Traditionally, minors have also not been able to give a legally valid consent to medical treatment unless they were "emancipated." However, a 1970 act of the General Assembly, Act 10,[1] has worked some rather significant changes in the traditional approach. (Act 10 is reprinted in full in the Appendix.)

Prior to the passage of Act 10, a physician or other clinician* who provided treatment to a minor, under the conditions not constituting an emergency or without the permission of the minor's parent or guardian, could be held liable for the tort of "battery" for which damages could be assessed.[2] This liability is to be distinguished from ordinary malpractice in which the physician has rendered medical care in a substandard manner. Liability for battery, by contrast, is predicated upon the rendering of medical care for which valid consent has not been obtained, irrespective of the expertise that the physician might possess, the degree of care exercised, and the success of the treatment provided. Until recently, the consent of the minor alone would have been no defense to a suit because the permission of a minor could not, in the eyes of the law, have constituted valid "consent." Of course, in an emergency situation where an attempt to obtain parental consent might have resulted in treatment being delayed, leading to death of or serious injury to the child, treatment could have been provided without incurring liability.[3]

The most far-reaching change in the law introduced by Act 10 is a provision reducing to eighteen the age at which an individual may give valid consent to medical treatment.[4] As a result of this provision, persons between the ages of eighteen and twenty-one may now obtain medical treatment on the same terms as those over age twenty-one. The physician still remains liable to the patient for any negligence in the rendering of medical care. However, as long as the minor patient has in fact consented to the treatment, liability may no longer be imposed for merely providing treatment to one eighteen years of age or older on the ground that the individual's consent was not legally valid.

Mr. Meisel is a research associate in psychiatry and director of the law and psychiatry section of the Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine. Reprints are available from the author at 3811 O'Hara St., Pittsburgh, Pa. 15261.

In addition to lowering to eighteen the age at which individuals may generally give valid consent to receive medical treatment, Act 10 established certain other classes of individuals under the age of eighteen whom a physician may treat in nonemergency situations with only the consent of the patient. If the patient (1) "has graduated from high school," (2) "has married," or (3) "has been pregnant," the consent of no one other than the patient is necessary before medical care may be rendered.[4] Another section of the act also enables minors to give effective consent (4) "to procedures to determine the presence of or to treat pregnancy," and (5) treatment for venereal disease and other communicable diseases.[5] Despite the somewhat inept syntax used in these statutory provisions, reason would dictate that the legislature intended that a minor who *is* married (as well as one who "has" married) or a minor who *is* pregnant (not just one who "has been" pregnant) may give a legally valid consent to obtain medical treatment.

Another section of the statute deals with the provision of medical care to children whose parents are themselves minors: "Any minor who has been married or has borne a child may give effective consent to medical, dental and health services for his or her child."[6] The language of the act, while somewhat obscure, appears to permit the minor *mother* of a child to consent to treatment of the child whether the mother is married or not. The power of the minor father to give consent to the treatment of the child is more closely circumscribed. It appears that the father may give a valid consent only if he and the mother are married to each other, though the language of the statute could be interpreted literally to mean that the father can give valid consent so long as he is married to someone, but not necessarily to the mother of

**The act appears to permit a minor to give effective consent, under specified circumstances, to receive medical, dental, and health services from any person who is legally empowered to render such services and not merely from a physician.*

the child. While this is certainly a plausible construction, it is not an entirely logical one; and in the absence of judicial consideration of the statute, no definitive answer can be provided as to its true meaning.

The legislation also seems to relax the rule of the common law permitting the dispensing of medical care in "emergency" situations. Under the new provision, treatment of minors may be undertaken without the consent of the minor's parent or guardian "when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life or health."[7] Previously, treatment of minors without valid consent was limited to situations in which the patient was in immediate danger[3] or death was likely to ensue. Thus, the statutory provision, rather than merely reiterating the common law, goes somewhat beyond it by permitting treatment without consent when a failure to commence treatment would merely increase the risk to life or health.

Two other legislative acts also bear on the issue of providing medical care to minors. Act 63, the "Drug and Alcohol Abuse Control Act"[8] permits the treatment of minors of all ages for drug or alcohol abuse without parental consent. For purpose of such treatment, the act makes "[t]he consent of the minor . . . valid and binding as if the minor had achieved his majority."[9] However, unless the minor has been directed to receive such treatment by court order, the actual consent of the minor is required before treatment may be administered or else the physician may incur liability for battery. The other legislative enactment specifically permits minors over the age of eighteen to donate blood without parental permission, though only to "voluntary and noncompensatory program[s]."[10]

Because of the large number of factual issues that determine whether a minor may render valid legal consent—such as age, marital status, graduation from high school, and parenthood—the legislature has also wisely sought to alleviate the burden on the physician of investigating the accuracy of the representations made by the minor. Thus, there is a provision in Act 10[11] protecting physicians and other health personnel from liability for battery when the physician was induced to render the treatment by factual representations of the minor which, unknown to the physician, were false. If, for example, a minor seeks treatment and states that his age is eighteen, but in fact the minor is only seventeen, the physician cannot be held liable for a battery so long as he has relied in good faith upon the minor's representation of age. Where, however, the physician entertains a reasonable doubt as to the minor's age—such as where the minor obviously has the appearance of a very young child—such reliance could be found not to be in good faith, thus exposing the physician to liability for battery for treating the child without a legally valid consent.

At present it is unclear what degree of inquiry must be made to assure oneself that the minor's representations are correct. Must the physician require that the patient produce a birth certificate, a high school diploma, or a marriage certificate before treatment can be rendered without fear of liability for battery? It would appear that such a requirement is not necessary. The legislature has only felt it necessary that the physician rely "in good faith" upon the minor's representations. That is, as long as the physician does not have actual knowledge of the falsity of the minor's representations, medical treatment may be provided without fear of being held liable for battery.

The enactment of these statutory provisions leaves unchanged the common law rule that an "emancipated" minor may also give valid legal consent to medical treatment. Who is an emancipated minor is not a simple issue to resolve since, as one legal treatise states, "the minor may be emancipated for some purposes, but not for others, and the parent may be freed of some of his obligations and divested of some of his rights, yet not freed and divested of others."[12] While emancipation of a child may occur as a result of express acts and statements of the parents, it may also be inferred from conduct and circumstances. Generally speaking, the following conditions evidence the emancipation of a minor child: (1) desertion, abandonment, or nonsupport of the child by the parents, (2) a self-supporting minor or a working minor who does not pay to his parents the proceeds of his employment, or (3) enlistment in military service, for the duration of the enlistment. It must be emphasized that this list is not conclusive and that there may be other conditions from which emancipation may be inferred.[13]

Conclusion

Several statutes enacted by the Pennsylvania legislature in the past few years have authorized the provision of medical, dental, and other health services to minors on the basis of their own consent alone without the knowledge or consent of the parents of the minor. These laws do not immunize physicians against all malpractice suits, however. They merely protect against suits for battery, that is for the unauthorized invasion of the human body irrespective of the degree of skill and care exercised.[14] When medical care is rendered to a minor, as to an adult, the physician is still liable for any harm to the patient resulting from a failure to exercise that degree of care, skill, and diligence customarily exercised by physicians generally in the community.[15] □

APPENDIX
Act 10

Act of Feb. 13, 1970, Pa. L. 19; Purdon's Statutes Annotated, title 35, sections 10101-10105.

Minors' Consent to Medical, Dental and Health Services

§10101. Individual consent

Any minor who is eighteen years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.

§10102. Consent for children with minor parents

Any minor who has been married or has borne a child may give effective consent to medical, dental and health services for his or her child.

§10103. Pregnancy, venereal disease and other reportable diseases

Any minor may give effective consent for medical and health services to determine the presence of or to treat pregnancy, and venereal disease and other diseases reportable under the act of April 23, 1956 (P.L. 1510), known as the "Disease Prevention and Control Law of 1955," and the consent of no other person shall be necessary.

§10104. When consent unnecessary

Medical, dental and health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life or health.

§10105. Liability for rendering services

The consent of a minor who professes to be, but is not a minor whose consent alone is effective to medical, dental and health services shall be deemed effective without the consent of the minor's parent or legal guardian, if the physician or other person relied in good faith upon the representations of the minor.

REFERENCES

1. 35 P.S. §§10101-10105; Act of Feb. 13, 1970, Pa. L. 19.
2. Zaman V. Schultz, 19 Pa. D & C 309 (1933).
3. Dunham v. Wright, 423 F. 2d 940, 941 (3d Cir. 1970) (applying Pa. law).
4. 35 P.S. §10101.
5. 35 P.S. §10103.
6. 35 P.S. §10102.
7. 35 P.S. §10104.
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Hepatic lipid in Reye's syndrome: histochemical and ultrastructural characteristics

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A SYNDROME in children characterized primarily by encephalopathy and fatty accumulation in viscera was described by Reye, Morgan, and Baral in 1963.[1] Since that time, this syndrome has been noted with increasing frequency, probably because of the education of the pediatrician and pathologist to recognize its essential features. These features include in many instances an antecedent, viral-type illness followed by protracted vomiting; the development of an encephalopathy without a concomitant encephalitis or meningitis; some evidence of hepatic dysfunction, usually in the absence of jaundice; and biopsy or autopsy evidence of fatty accumulation in viscera, particularly the liver.

A complete morphologic characterization of the accumulated lipid in the liver in Reye's syndrome is desirable from the standpoint of the pathologist in so far as it may facilitate diagnosis. In addition, knowledge gained from such a characterization, when taken in context with other known clinicopathologic features of the syndrome, may provide additional insight into its pathogenesis and thereby suggest specific therapeutic approaches.

The purpose of this paper is threefold: (1) to characterize both histochemically and ultrastructurally the accumulated lipid in the liver in Reye's syndrome; (2) to correlate these morphologic findings with the results obtained by chromatographic and chemical analyses[2,3] and with certain physiopathologic aspects of the syndrome; and (3) to suggest a specific disease-oriented therapy for Reye's syndrome based both on the known physiopathologic aspects of lipid metabolism in it (as reinforced by the findings in this study) and on its clinicopathologic features.

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Materials and Methods

Four cases of Reye's syndrome from the files of the Armed Forces Institute of Pathology (AFIP) were studied. In three cases formalin-fixed portions of liver were used, and in one other case glutaraldehyde-fixed, osmium-postfixed tissue was studied. Documentation of Reye's syndrome in these cases included the exclusion of a primary effect of drugs on the general histopathologic and cytopathologic features.

Frozen sections of the formalin-fixed tissues were stained with oil red O (ORO) for lipids, 1.0 percent osmium tetroxide for lipids, periodic acid-Schiff (PAS) reagent with and without diastase for glycogen and with and without methanolchloroform extraction for glycolipids, and Luxol fast blue for phospholipids. Baker's method for phospholipids, Fischler's method for free fatty acids, and Schultz's method for cholesterol were also used. The accumulated lipid was also checked for birefringence. The amount of stainable lipid in each section was

TABLE I
Hepatic Lipid Demonstrated Histochemically*
in Reye's Syndrome

Stain or Method	Case 1	Case 2	Case 3
Oil red 0 (lipids)	++++	++++	++++
1% Osmium tetroxide (lipids)	++++	++++	++++
Periodic acid-Schiff (PAS) (glycolipids)	0	0	0
PAS with methanol-chloroform extraction (glycolipids)	0	0	0
Luxol fast blue (phospholipids)	0	0	0
Baker's method (phospholipids)	0	0	0
Fischler's method (free fatty acids)	0	0	0
Schultz's method (cholesterol)	0	0	0

*Range of intensity of positivity reckoned on scale from 0 to 4+

graded on an arbitrary scale ranging from 0 to 4+.

The tissue for electron microscopy was dehydrated and embedded in epoxy resin. "Thick" thin sections (1 μm) were stained with toluidine blue. Thin sections were stained with uranyl acetate and lead citrate and examined in an RCA EMU 3-G electron microscope.

Results

Attempts to demonstrate the presence of glycolipids, phospholipids, free fatty acids, and cholesterol were unsuccessful (See Table I). Cholesterol esters were believed not to be present because the lipid was not birefringent. The frozen sections stained with ORO and osmium tetroxide, however, showed positive results in all three cases. This lipid was generally distributed throughout the lobule, but occasionally there was noticeably less lipid in periportal hepatocytes. Furthermore, the lipid droplets were usually small and uniform in appearance, did not displace the nucleus of the hepatocyte, and did not generally fill the cytoplasm (Figs. 1 and 2). Their numbers varied from cell to cell within each case.

Thick thin sections (1 μm) of the Epon-embedded material also demonstrated the lipid droplets (Fig. 3) when stained with toluidine blue. Ultrastructurally one of the characteristics of the accumulated lipid droplets was the occasional presence of osmiophilic dense material, possibly lipomicrons,[4] located primarily at the interface between the lipid droplet and the cytoplasm of the hepatocyte (Fig. 4).

Discussion

This study indicates that the major portion of the accumulated lipid in the liver in Reye's syndrome is neutral lipid, probably triglyceride. This conclusion is based on the following: (1) the absence of histochemically demonstrable amounts of glycolipids, phospholipids, free fatty acids, and cholesterol and the absence of cholesterol esters as determined by polarized light; and (2) the similarities between the demonstrable lipid in the hepatocyte in Reye's syndrome and that stored in adipocytes. These similarities include the positive reaction with ORO, which stains the lipid in adipocytes, and the ultrastructural appearance of the lipid droplets.[4]

Furthermore, these morphologic findings are in agreement with both the studies of lipid in blood in Reye's syndrome, which indicated an absence[2,5] of hyperlipoproteinemia, hypercholesterolemia, and hyperphospholipidemia, and with the chromatographic and chemical analyses on extracted hepatic lipid, which showed that the accumulated lipid was predominantly triglyceride.[2,3] Our histochemical studies failed to demonstrate free fatty acids in the liver, however, which some investigators[3] have shown to be elevated. On the other hand, because free fatty acids are more likely to be bound to membranes or to proteins at the interface between the fat droplet and the cytoplasm, there may not have been sufficient concentrations for their detection by histochemical means.

The known physiopathologic aspects of Reye's syndrome are consistent with our findings and those of others. Both excessive free fatty acidemia (as evidenced by changes in adipose tissue stores[6] by elevated plasma or serum-free fatty acids,[3,5] and by ketosis[7]) and hypoprebetalipoproteinemia[5,8] (as demonstrated by agarose gel elec-

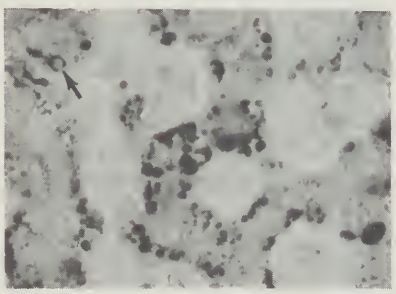

Fig. 1. Number and size of lipid droplets vary from one hepatocyte to another. An occasional empty vacuole is surrounded by lipid (arrow) (oil red 0, X720; AFIP Neg 73-3916).

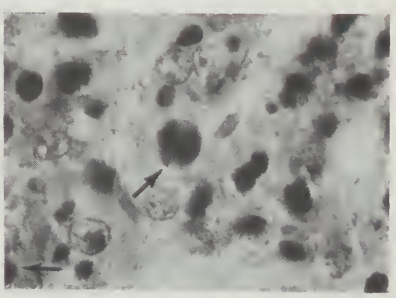

Fig. 2. Lipid droplets (arrows) in the hepatocytes demonstrated by osmium tetroxide staining of frozen section (1 percent osmium tetroxide, X835; AFIP Neg 73-3915).

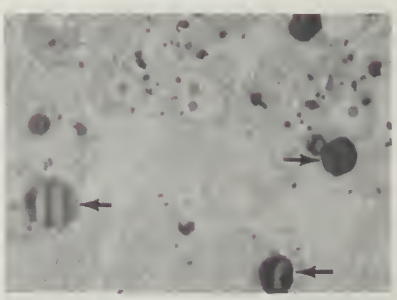

Fig. 3. Lipid droplets (arrows) in hepatocytes (glutaraldehyde-fixed, osmium-postfixed, Epon-embedded 1-μm sections stained with toluidine blue, X1, 200; AFIP Neg 73-3914).

trophoresis in Reye's syndrome) could account for the results obtained by chromatographic and chemical analyses and for our morphologic findings. The former would provide excessive amounts of fatty acids to visceral organs such as the liver to be re-esterified to diglycerides and triglycerides, and the latter would retard the mobilization of triglyceride from the hepatocytes.

In general, the amount of morphologically or chromatographically demonstrable lipid in the liver or other viscera in Reye's syndrome at any one given time (such as a biopsy or autopsy specimen would represent) depends on the interplay of many factors. This interplay would involve factors or circumstances that should enhance lipid accumulation in viscera (such as lipolysis and mobilization of fatty acids, re-esterification of fatty acids, and the decreased production of lipoproteins) and those factors or circumstances that would tend to decrease lipid accumulation (such as ß-oxidation of fatty acids, hydrolysis of accumulated triglyceride, impaired cellular function extending to include the relative ability to re-esterify fatty acids, and the possible competition of fatty acids with other substances such as bilirubin and drugs for sites on the smooth endoplasmic reticulum in the hepatocyte).[9,10] These points should be kept in mind in considering the pathologic spectrum of this disease process and entertaining the diagnosis of Reye's syndrome.

From a practical standpoint, the evidence for excessive lipolysis with mobilization of fatty acids in Reye's syndrome has certain therapeutic implications. Not only could the presentation of excessive amounts of fatty acids to the liver and certain other organs result in the accumulation of metabolites such as triglycerides in their parenchymal cells (as further substantiated by this study) but also because of their potentially toxic effect, fatty acids can be and have been implicated[11] in the pathogenesis of many of the clinicopathologic features (including both metabolic and systemic disturbances) of Reye's syndrome. In this regard, antilipolytic agents such as insulin and hypertonic glucose have been recommended[12] as a form of specific disease-oriented therapy. Although the experience with this form of therapy is currently limited,[13] and in spite of certain potential therapeutic pitfalls,[14] the preliminary data are encouraging.

Summary

Histochemical and ultrastructural studies in Reye's syndrome were carried out on sections of liver in an attempt to characterize the lipid present within the parenchymal cells.

These studies suggest that the accumulated lipid is predominantly neutral lipid, probably triglyceride. This finding is consistent with the results that others have obtained by chromatographic and chemical analyses and with certain of the physiopathologic aspects of this disease process. Furthermore, the results of these studies reinforce the evidence for excessive lipolysis with mobilization of fatty acids in Reye's syndrome and thereby support the argument for using antilipolytic therapy to treat it. □

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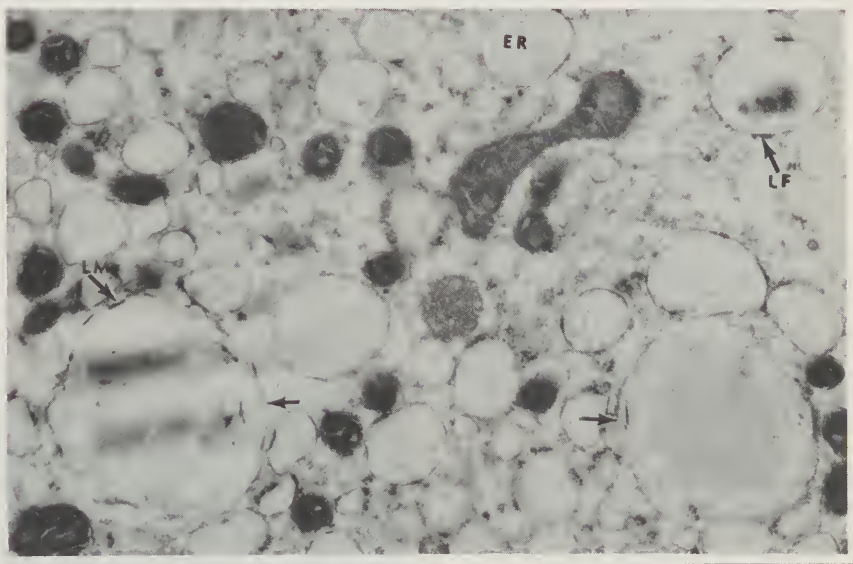

Fig. 4. In addition to the lipid droplets (arrows) note the occasional presence of osmiophilic material, possibly lipomicrons,[4] at the interface between the lipid droplet and the cytoplasm (arrow LM). Similar material could also be found on the membrane of the dilated cisternae of smooth endoplasmic reticulum (ER). Lipid-like material within such cisternae (arrow LF) suggests that the cisternae are a site of lipid formation in the hepatocyte in Reye's syndrome (glutaraldehyde-fixed, osmium-postfixed section stained with uranyl acetate and lead citrate, X28, 300; AFIP Neg 73-4016).

Regionalization of continuing medical education

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WITH the present acceleration in medical technology and scientific advances, there is an ever-increasing need for the doctor to continue learning after he graduates. Consequently, there is a growing demand on the medical school faculty to participate in the continuing educational process. It is now becoming evident that the faculty residing primarily in the medical school hospital is unable to meet this need, and the need for additional physicians with academic capability has become evident.

Furthermore, the increasing complexity and diversification of medical school education leads to a fragmented experience, so that emphasis must be placed on the methodology of learning rather than on the accumulation of specific facts. This leads to additional demands for programs to meet the continuing education needs of the physician after graduation.

To meet these needs, the department of medicine of the Hahnemann Medical College (in 1969, when Dr. Moyer was department chairman) and its affiliated hospitals created the Regional Council for Continuing Medical Education. This was extended into a School for Continuing Education in 1972, organized around the same administrative format, but also including all of the academic departments which participated in the continuing education program of Hahnemann and its affiliate system.* In the process of development and implementation of the continuing education programs, a number of deficits in the system of continuing education as it existed in 1969 had become evident. It was observed that:

(1) The medical college faculty itself was overextended and could not continue to respond to necessary requests in continuing medical education.

(2) Many programs in continuing education were not founded on sound principles of learning and were consequently ineffective.

(3) Programs of continuing medical education were not and still are not relevant to the needs of the patient and the physician.

(4) Duplication dilutes the impact of continuing medical education programs and adds to manpower and financial expenses.

(5) The concept of medical education as a continuum was not being incorporated into newly developing programs.

Medical School Affiliations

In order to meet the needs of undergraduate medical education and at the same time improve the delivery of health services in affiliated hospitals, two types of affiliation arrangements with community hospitals have emerged. Each type of arrangement is related to the facilities of the institutions involved and to common objectives of the medical college and its affiliated hospitals. All such affiliations are structured about formal contractual agreements, with continuing education of the affiliate hospital staff being the first and basic consideration. Certain features are common to all types of agreements: namely,

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**Administrative changes at the Hahnemann Medical College have disrupted implementation of these programs since this manuscript was submitted. Nonetheless, the significance of this concept remains and for that reason is being published at the request of the authors.*

they are long-term agreements; they have a bilateral commitment clause; and they outline the mechanics of future operations and program development. Beyond this, the agreements differ depending on the type of affiliation.

The first type of affiliation is for the student-resident teaching affiliates—both Metropolitan Philadelphia and distant affiliates. Usually the resident training programs are integrated in the metropolitan area affiliates, whereas the training programs at distant affiliates are independent. Otherwise the agreements for these major affiliates are similar. In addition to items previously mentioned, these agreements contain clauses requiring salaried department heads; uniform departmental structure; review of active staff applications for faculty appointment; and selection of department heads by departmental liaison committees made up of equal representation from the corresponding departments at the medical school and at the affiliated hospital. (Fig. 1)

The second type of affiliation is restricted to continuing education programs. In addition to common clauses of all agreements, these contracts contain the following clauses: (1) A commitment from the affiliating hospital to develop or continue in a program of patient care evaluation; (2) The appointment of an individual responsible for the program in continuing education together with appropriate remuneration; (3) Provision for the support of facilities required; (4) Provision for the financial support of a continuing education program, including honoraria, travel, and overhead for program operation; (5) Agreements to permit phasing in of any departments other than those participating initially, when agreeable to the heads of the departments involved at both institutions. (6) A stipulation that the agreements involve allied health personnel; and (7) Permission for any continuing education affiliate to become involved in other aspects of medical education whenever appropriate if approved by an inter-institutional reviewing committee. These agreements are open-ended.

This last clause of the agreements allows for additional major teaching affiliates for an expanding student body, and it is intended to provide opportunities immediately for a broader variety of experience for the students on an elective basis. Further, this sequence in the development of affiliation is predicated on the firm belief that the more progressive affiliations are those structured about an active, alert medical staff, involved in continuing education, rather than bricks and mortar. Continuing education is the basis and common building block for all affiliates.

As many as twenty hospitals could become involved in the program as continuing education affiliates (See figure 2). On the basis of current capacity to provide effective direction and administrative services, this is as large a complex as can be handled. Relating to this size group of hospitals on a continuing basis will have several advantages, both for the medical school and for the affiliates. It will permit the affiliates to contribute more to the planning of continuing medical education at the medical school; permit more involvement of their medical staffs; allow programs to be evaluated (now virtually impossible for the unaffiliated hospital and impractical for too large a number of affiliates); and promote regional and subregional cooperation in academic programs.

The School of Continuing Education

The primary purpose of the school is to enlarge and advance the medical knowledge of practicing physicians and allied health professionals and thus to improve patient care. In keeping with that purpose, the school is responsible for developing and implementing *all* continuing ed-

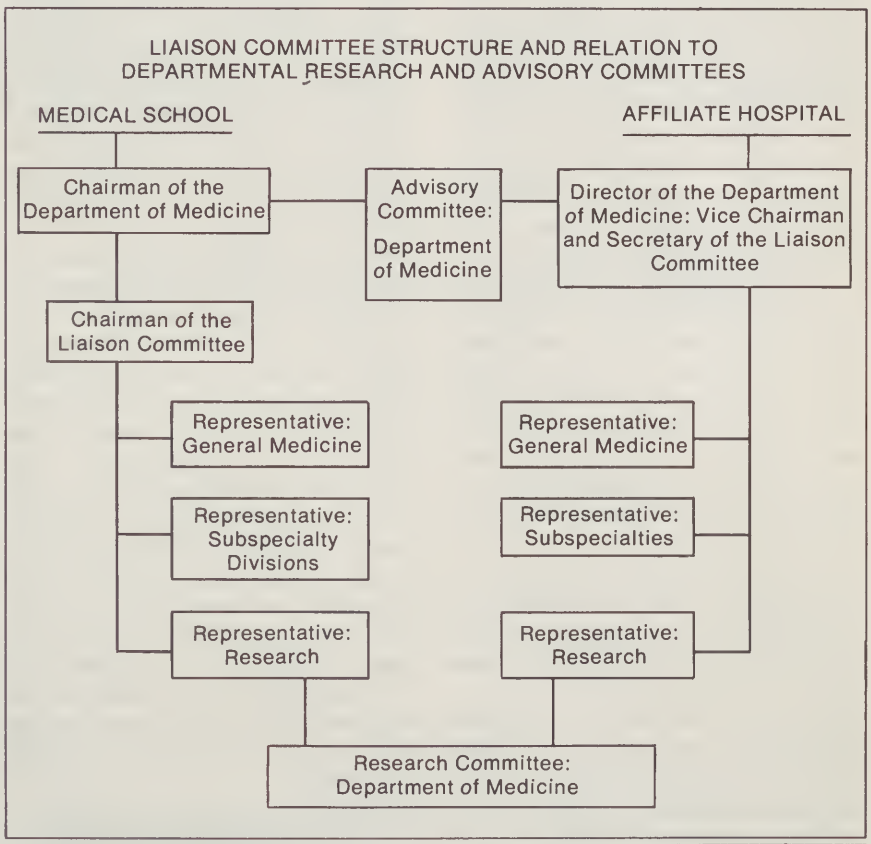

Figure 1. Structure of the liaison committee of each department consists of representatives from the department at the medical school and parallel representatives from the department at the affiliate institution. All planning and policy development between the medical school and the affiliate institution is communicated through this liaison committee. In addition, the liaison committee relates to the departmental research committee as well as the advisory committee to each departmental chairman.

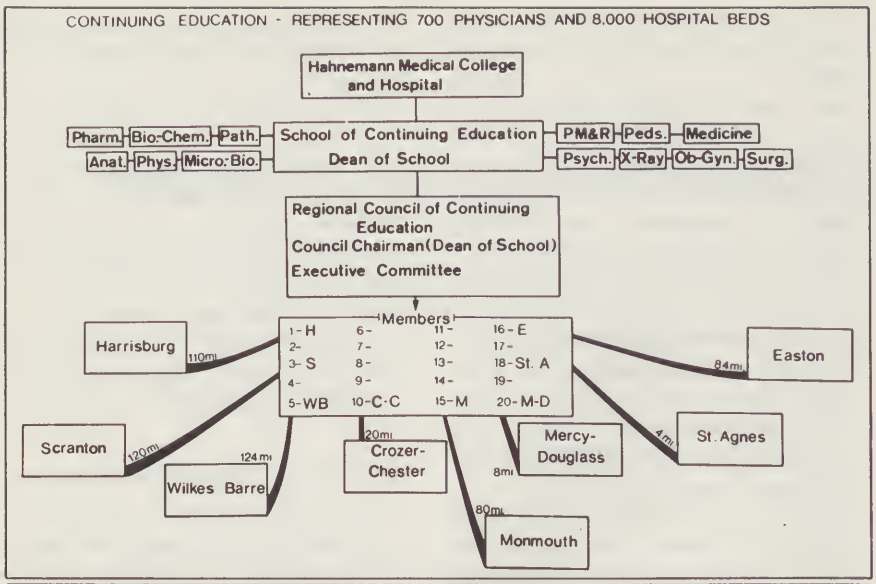

Figure 2. Structure of the Regional Council for Continuing Education includes representatives from the various participating community hospitals and the participating departments at the medical school.

ucation programs of the medical school and its affiliated institutions. Working with individual directors or departments of medical (continuing) education at the affiliates, the office of the school arranges and coordinates programs relevant to identified needs at each affiliate. In addition, however, it seeks to eliminate duplication of effort through coordination of regional programs.

A dean heads the school and a regional council for continuing education supervises its activities. Each of the participating affiliated institutions is represented on this council, which is responsible for the development of policies and procedures that will improve the educational programs of all participating hospitals. The dean, who serves on a part-time basis and is chairman of the council, is appointed upon recommendation of the council. *Preference is given to a representative from one of the affiliate institutions so as to keep the activities of the school in proper perspective.* The school also has one full-time associate dean and one part-time associate dean, with regional assistant deans as indicated. One associate dean is directly responsible for the continuing education programs for physicians and physician assistants. Working with him is a coordinator for the allied health sciences. A regional assistant dean will be appointed whenever a regional health education center materializes or the affiliated hospitals in any one geographical area reach a sufficient number to warrant a regionalized integrated program. Finally, the school has an executive director in charge of administration with an appropriate secretarial staff.

Operational services of the school are available to all departments of the medical college as well as to the affiliates, working through the dean; and all departments are expected to participate in the continuing education effort when participation of their disciplines is appropriate. The school is responsible for program announcements, for financial matters related to the continuing education programs, for evaluating programs and attendance, and for preparing and publishing an annual report. It shares the responsibility for preparing annual reports of the programs at each affiliated institution with their directors of medical education.

Regional Council on Continuing Education

The department of medicine took the initiative in organizing the council about a nucleus of the directors of medical education of the affiliated hospitals and staff members from the medical college representing each department that participates in the continuing education program. The primary and simple charge to the council is the improvement of patient care in all the hospitals affiliated with the medical college through sound programs of continuing education.

The council consists of the dean of the School of Continuing Education, who serves as chairman; the executive director of the school, who serves as secretary; the associate and assistant deans of the school; the chairman of each academic department of the medical college which actively participates in continuing education (or his designee as deputy chairman with full authority); one representative from the College of Allied Health Professions; two members of the nursing staff stationed at the medical college, one of whom is nominated by the School of Nursing from its faculty and the other nominated by the vice president for medical affairs; two representatives from the student body, one of whom is appointed by the dean of the medical college and the other nominated by the students; and from each affiliated institution, one representative from the clinical services and one from the allied health professions where appropriate (See Fig. 2). When the chairman of a department with representation on the council designates a deputy chairman to represent him on a regular basis, he establishes that fact by notifying the dean of the school in writing. This representation remains in effect through automatic renewal on July 1 of each year unless the departmental chairman notifies the dean otherwise at that time.

The council is responsible for developing the organizational framework of the continuing education program and the policies and procedures for directing future operations. The dean and his staff are subsequently responsible for developing programs relevant to identified needs with each affiliate or group of affiliates. The programs of each affiliate institution (or group) are reviewed periodically by the council. The School of Continuing Education, together with its affiliate

institutions, has been approved by the Council on Education of the American Medical Association, so that programs at the affiliates are automatically accredited as soon as they are planned and developed as part of the activities of the school.

All representatives from the affiliated hospitals and the medical school meet once a month, or as often as necessary to develop general policies governing the program. As the number of affiliated hospitals grows, an executive committee will be formed. It will include the chairman and vice chairman of the council, an educational consultant, two representatives from the Philadelphia metropolitan area affiliates and two from the distant affiliated hospitals, and the executive director of the school, who is secretary of the council. Meetings of the executive committee will be dictated by the needs of the overall program.

Subcommittees of the council are structured to accomplish various tasks. These include: review of applications for appointment to the continuing education faculty; evaluation of affiliated institutions for changing affiliated status (i.e., moving from one type of affiliation to another); and evaluation of student elective assignments in the continuing education affiliates (those whose affiliation is restricted to this area). The operation of the academic programs in the student-resident affiliates is the responsibility of their liaison committees, in which their representatives to the council will participate.

The Program in Continuing Education

Recognizing the broad spectrum of needs in continuing education, the program is diversified and structured to be flexible and adaptable to specific needs. Faculty members are available for service in the affiliate hospitals as visiting professors, lecturers, and consultants in educational methodology and delivery of health services. They participate in circuit courses, patient care evaluation programs, sequential patient care analysis, etc. These are supplemented by back-up programs at the medical college hospital, such as symposia, seminars, and in-house trainee tutorial programs.

Patient Care Evaluation—One of the major requirements of the continuing education type of affiliation is the establishment of a system of patient care evaluation (See Fig. 3). If requested, members of the council and faculty will assist any affiliating hospital in the development of such a system and advise on the on-going programs of patient care evaluation in the affiliated hospitals. Workshops will be organized by the council to provide for a sharing of experiences in this area, the development of new programs of patient care evaluation, and the establishment of criteria of care that are broadly applicable yet adaptable to specific institutional needs. Interestingly, the newly developing groups of affiliated hospitals have diversified data bases. Some are involved in the Professional Activity Study (PAS); others in the Hospital Utilization Project (HUP); and still others in their own data collection systems. This diversity is highly desirable in developing future systems, both for educational purposes within the affiliated complex of hospitals and, equally important, for the medical student body.

From whatever the data base, it is anticipated that patient care needs and physician practice deficits will be identified by matching the data against criteria established by individual medical staffs, in workshops sponsored by the council, and from other sources. Herein lies the foundation of the program in continuing education to be developed for each participating hospital, or subregion where appropriate.

As physician self-evaluation programs become more prevalent, it is hoped that these too will become a source of data for educational needs, especially for the programs based at the medical college (e.g., the international symposia, subspecialty seminars, and tutorials). The continuing education activities of the regional council will relate primarily to the programs within the affiliated hospitals, the cornerstone of true continuing education related to the management of patients. The

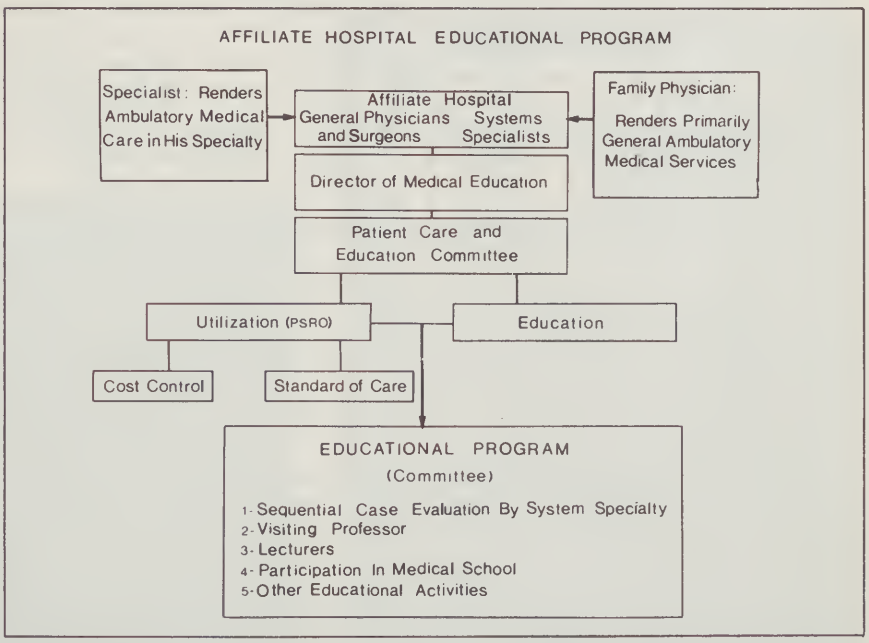

Figure 3. Structure of the affiliate education program. The director of medical education is responsible for the overall coordination of continuing education of the affiliate. The utilization committee considers the standard of health care as well as cost control. It is important that two subcommittees are formed one of which includes administrative personnel to consider cost control operating independently of the other which should consider quality medical care. The two different areas are then coordinated through the parent utilization committee. The education committee is independently responsible for the quality of education and for deficits that become apparent through the subcommittee on Standard of Care.

community hospital thus becomes a secondary center for continuing education for family physicians responsible for primary care of patients in that community.

The Continuing Education Faculty

A nucleus of continuing education affiliates to which the medical college relates continuously over a long period of time has several inherent advantages. One of these is the identification of faculty members within the affiliate institutions who have the background, qualifications, and desire to participate in educational programs, but who previously were not so identified because the institution was not part of a formal medical school educational program. Those who are found to have such qualifications will be given faculty appointments on the continuing education faculty. It is anticipated that this will not only increase the participating faculty numerically, but will also have the advantage of broadening the base of experience. Additionally, loss of considerable time in travel by the school's faculty may be avoided as these faculty members become involved in programs near their home base of operation. As the overall programs grow, subregional units built about such faculty and their institutions may be established. Faculty members from continuing education affiliates will be reimbursed with the standard honoraria and expense items.

Faculty Responsibilities—(1) Visiting Professor Programs. Though a basic format is recommended, it may be altered as desired by the host institution, working with the office of the school of continuing education and the visiting professor himself. The usual program involves at least one-half day to a full day. It is anticipated that in the future such visitations may be extended over a number of days. Starting with case conferences involving the physicians and their patients, the day proceeds through a formal presentation followed by a generous question and answer period, and then on to informal unstructured discussion groups or any other activity related to the needs of the medical staff. Determination of criteria for patient care is an important part of these sessions.

(2) Visiting Lectureship Program. This comprises courses consisting of monthly presentations that range from a broad general course in internal medicine to a more comprehensive coverage of a specific subspecialty area. "Recent Advances in . . ." would be covered by this category of program. Although the usual format is the lecture, it may be varied to include discussion groups, panels, etc. Programs of this type are available for isolated lectures to county medical societies and other such groups. It is recommended that these presentations be oriented primarily to new scientific developments and discoveries.

(3) Tutorial Programs. These are available by special arrangement for selected individuals at the medical college hospital. Physicians sponsored by affiliated hospitals (or on their own initiative) may participate in tutorial programs already available at the medical college, or special programs will be designed as necessary if not currently listed. These are in-house training programs of no less than two weeks. The trainee can develop a program lasting as long as nine months by arranging sequential assignments in different units of the hospital.

Medical Student Programs

Medical students are closely involved in many aspects of council activities. Each of the major teaching affiliates presents a series of seminars educating students in the practical aspects of medical practice, including community resources, medical staff structure, and committees, etc., and in patient care evaluation proceeding currently in its own institution. As this is the starting point of all continuing education, it is essential that the student be exposed to and involved in such learning experiences. Additionally, students are involved in programs related to data systems, computer technology, and problem-oriented records.

Students working in clinical assignments at the affiliates and with preceptors are further involved in actual programs based at the affiliates. With individual preceptors, who may well be participating faculty, they also become involved in program development.

One of the intriguing aspects of student involvement is their exposure to newly developing learning resources centers in some affiliated hospitals. The transition from traditional libraries to resource centers employing all modalities and technologies for self-teaching is a stimulating and worthwhile experience.

Summary

In summary, the Regional Council on Continuing Education has been established to serve as the organizational mantle for continuing education at the medical college and affiliated hospitals. It has as its primary objective the improvement of patient care in all participating hospitals. Secondary objectives include: (1) augmentation of faculty; (2) limitation of faculty involvement to a smaller number of institutions and medical staffs, on a continuing basis; (3) organization of programs about identified patient care needs and physicians' deficits in knowledge and practice; (4) employment of sound educational methodology in programs already established; (5) involvement of medical students in continuing education as a continuing experience throughout their undergraduate years; and (6) coordination of programs to avoid duplication.

The network of continuing education established through the council will have a meaningful impact on patient care. It makes the precious hours each physician devotes to his continuing education more productive and worthwhile. It provides a vehicle for research in continuing education never before available. (There are already significant explorations of the use of audiovisual systems in this network.) The council looks to corporations, private foundations, and regional medical programs for resources to assist in the developmental years. The program is ultimately projected to be self-supporting. □

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*AVAILABLE ON REQUEST: Ronald J. Goldberg, M.D. & Franklin J. Shulman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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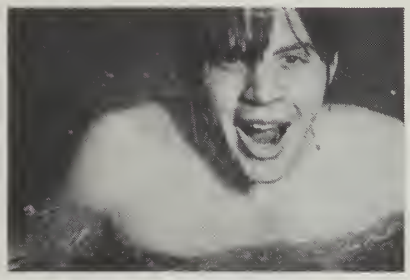

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Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

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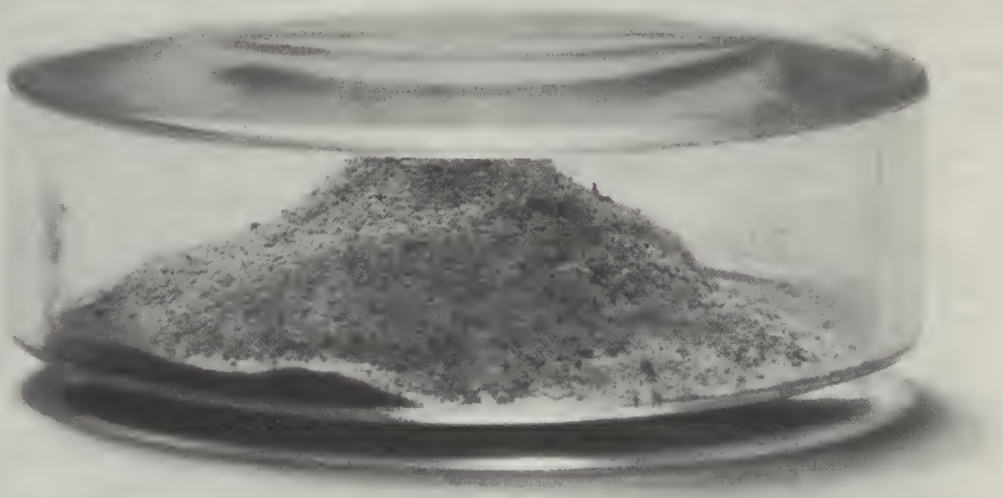

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continuing education

This issue carries no education course listings. Beginning in September, continuing medical education announcements will be published only twice a year in a special continuing medical education supplement to PENNSYLVANIA MEDICINE.

June 15, 1974, is the deadline for receipt of announcements to be printed in September. Mail all data (date, place, sponsor, subject) to:

Pennsylvania Medical Continuing Education Institute
20 Erford Road
Lemoyne, Pennsylvania 17043.

It is important to meet the June deadline, since delay will result in a six month wait until the January edition.

To obtain a copy of the continuing medical education announcements that are recorded at the Institute Office, write to the above address.

obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Joseph P. Atkins,** Philadelphia; University of Pennsylvania School of Medicine, 1934; age 64; died March 2, 1974. Dr. Atkins was professor and chairman of the department of bronchoesophagology at the University of Pennsylvania School of Medicine. He was a professor and former chairman of the department of bronchology, esophagology, and laryngeal surgery at the graduate school. He was a past president of the American Bronchoesophalogical Association and of the Pennsylvania Academy of Ophthalmology and Otolaryngology. He is survived by his wife; three daughters; and six sons, one of whom is Joseph P. Atkins, Jr., M.D., Olney, Md. A brother, John L. Atkins, M.D., Baltimore, Md., also survives him.

• **Sylvio J. Barra,** Reading; University of Arkansas School of Medicine, 1938; age 68; died March 5, 1974. Survivors include his wife, three daughters, a son, and a sister.

• **Samuel R. Black,** Kittanning; University of Pittsburgh Medical School, 1943; age 52; died February 20, 1974. He was a member of the American Urological Association and a diplomate of the American Board of Urology. He was also a fellow of the American College of Surgeons and a member of the Pan-American Surgical Society. He is survived by his wife, two daughters, two sons, and a sister.

• **Franklin E. Chamberlin,** Ocean City, N.J.; Temple University School of Medicine, 1923; age 80; died March 1, 1974. He was a past president of the Delaware County Medical Society. He practiced in Glenolden for many years. His wife, two daughters, and a brother survive him.

• **Donald F. Closterman,** Kingston; Hahnemann Medical College, 1931; age 66; died February 22, 1974. He was chief of the department of medicine at Nesbitt Hospital. He was a fellow of the American College of Physicians, a diplomate of the American Board of Internal Medicine, and a fellow of the American College of Cardiology. Survivors include his wife, one daughter, one son, two sisters, and a brother.

• **Douglas A. Decker,** Allentown; University of Pittsburgh School of Medicine, 1930; age 69; died January 23, 1974. He specialized in dermatology. Information regarding survivors is unavailable.

• **Marjorie Ann Meyer,** Drexel Hill; Woman's Medical College, 1946 (Medical College of Pennsylvania); age 52; died February 19, 1974. No further information is available.

• **Von D. Mizell,** Ft. Lauderdale, Fla.; Meharry Medical College, 1936; page 63; died July 16, 1973. No further information is available.

• **Leslie E. Morgan,** Scranton; Jefferson Medical College, 1931; age 73; died March 10, 1974. He had practiced medicine in Scranton for more than forty years. His wife and a son survive him.

• **John L. Mulherin,** Philadelphia; Temple University School of Medicine, 1936; age 66; died February 5, 1974. He is survived by two sisters.

• **John A. Murray,** Patton; Jefferson Medical College, 1931; age 68; died January 29, 1974. He had served on the staff at Miners Hospital of Northern Cambria in Spangler for forty years prior to his retirement. He is survived by his wife; a daughter; and two brothers, one of whom is Richard C. Murray, M.D., Patton.

• **Bryce E. Nicodemus,** Lewistown; Jefferson Medical College, 1935; age 64; died February 7, 1974. He had served as chief of staff and head of the department of pediatrics at Lewistown Hospital for many years. He is survived by his wife; two daughters; and three brothers, one of whom is Roy E. Nicodemus, M.D., Danville.

• **Mary M. Paulosky,** Minersville; Middlesex University School of Medicine, Waltham, Mass., 1928; age 73; died February 18, 1974. She had practiced medicine in Reading for twenty-six years. She is survived by a brother.

• **Arthur A. Paluso,** Charleroi; Jefferson Medical College, 1924; age 74; died January 29, 1974. He is survived by three brothers, all of whom are physicians: Arthur K. Paluso, M.D., Charleroi; and Eugene F. and John R. Paluso, both Washington physicians.

• **Reginald W. Pinckney,** Willow Grove; State University of Iowa College of Medicine, 1929; age 71; died February 19, 1974. He was on the emeritus staff of Abington Memorial Hospital, Willow Grove, and Holy Redeemer Hospital, Meadowbrook. He is survived by his wife and a son.

• **Emil Sposato,** Amity; Temple University School of Medicine, 1933; age 66; died February 11, 1974. He was a member of the staff at Washington Hospital. His wife and a brother survive him.

• **Joseph Shilen,** Miami, Florida; George Washington University School of Medicine, 1910; age 81; died February 18, 1974. Survivors include his wife, two daughters, and a son, Thomas S. Shilen, M.D., Coral Gables, Florida.

• **Bernard G. Slipakoff,** Philadelphia; Temple University School of Medicine, 1934; age 64; died October 7, 1973. No further information is available.

• **Krikor Yardumian,** Pittsburgh; American University of Beirut, Beirut, Lebanon, 1915; age 81; died February 28, 1974. He was chief pathologist for Montefiore Hospital prior to his retirement. He was director and professor emeritus of the School of Medical Technologists at Montefiore and clinical professor at the School of Dental Medicine, University of Pittsburgh. He was a past president of the Pittsburgh Pathological Society and a member of the American Society of Clinical Pathologists and the Association of American Bacteriologists and Pathologists. He is survived by his wife, a daughter, and a son.

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Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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pennsylvania medicine

JULY 1974

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medigram

July 1974

PSRO COOPERATION VOTED The AMA House of Delegates at its June session voted 185 to 57 to cooperate with the Professional Standards Review Organization (PSRO) law, but to work for necessary amendments. The resolution adopted reads:

> "Resolved, That this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further
> Resolved, That the Association should continue its efforts to achieve legislation which allows the profession to perform peer review in accordance with the profession's philosophy and the best interests of the patient; and be it further
> Resolved, That individual state associations which select non-participation shall not be precluded from such a position by this Association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further
> Resolved, That if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely affect the quality of patient care, or conflict with Association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings."

SOCIETY TESTIFIES AT MALPRACTICE HEARINGS A. Reynolds Crane, M.D., Society president elect, testified at Insurance Department hearings June 18 in Philadelphia. He said the informed consent problem in Pennsylvania and the contingency fee system are contributing to the rising number of malpractice suits filed and he called on the department to assist the Society to alleviate the situation. Eli T. Bernzweig, J.D., vice president of Argonaut Insurance Co., underwriter of the Society-sponsored professional liability insurance plan and formerly director of the Commission on Malpractice of the Department of Health, Education, and Welfare, cited the company's loss prevention education program, "Medical Alert Communications," as an educational tool useful in loss prevention. Details will appear in the August issue of PENNSYLVANIA MEDICINE.

SENATE APPROVES NEW MEDICAL PRACTICE ACT The Senate has approved House Bills 759 and 760, the Society-supported legislation establishing a new "Medical Practice Act." The bills passed the House of Representatives last December. The bills now return to the House for concurrence in the Senate amendments to H.B. 760 which: permit nurses to perform medical acts agreed to by the Nursing Board and the Medical Board; delete a section which would have given the Medical Board authority to regulate paramedical personnel; and eliminate hypnosis from the scope of the bill. As a result of Senate action on an amendment to H.B. 759, the companion bill establishing the State Board of Medical Education and Licensure and describing its power and duties, would remain in the Bureau of Professional and Occupational Affairs rather than be transferred to the Department of Health.

FOUNDATION REQUESTS MEETING WITH GOVERNOR After learning of a Department of Health proposal to establish a statewide utilization review and quality appraisal system for hospital care, the Board of Directors of the Pennsylvania Medical Care Foundation at its June 16 meeting requested a meeting with Governor Milton J. Shapp to discuss the project. The Board said the project is in conflict with the federal PSRO law, ignores the accomplishments of the Foundation in the field, was developed without input from the Pennsylvania Medical Society or the Foundation, and may be a duplication of efforts already being implemented in PSRO areas throughout the state.

MALPRACTICE INSURANCE RATES UP Insurance Commissioner William J. Sheppard has announced the approval of rate increases for professional liability insurance for Medical Protective Co. and Aetna Casualty and Surety Co. Aetna's overall increase is 59 percent, including a 12 percent reduction in the five-county Philadelphia area. Overall increase for Medical Protective, including coverage of dentists, is 44 percent. Filing of a rate increase request by Argonaut Insurance Co., underwriter of the program sponsored by the State Society, can be expected in the near future.

NEW IMMUNIZATION RULES PROPOSED The Department of Health published in The Pennsylvania Bulletin for June 22 a proposal requiring as a condition of school attendance immunization against diphtheria, tetanus, poliomyelitis, and measles. Written comments will be accepted for thirty days. The department also asked interested parties to submit written comments on whether or not school children should be immunized against rubella, for which no proposed regulation has yet been written. The State Society favors immunization of school age children against rubella and has so indicated to the Advisory Health Board.

WORKMEN'S COMPENSATION PLAN PAYS DIVIDEND State Society members covered by the Society-endorsed workmen's compensation insurance program have received a dividend of 35 percent on their first premium. Checks from Casualty Reciprocal Exchange, underwriter of the program, were mailed June 12, with a letter from Society President Ralph C. Wilde, M.D.

GOVERNOR NAMES ACTING SECRETARY James Radcliffe Harris, M.D., Philadelphia, has been named acting deputy secretary for mental health and medical services in the Department of Public Welfare by Governor Milton J. Shapp. Dr. Harris has served as director of the Southeast Philadelphia Neighborhood Health Center, Director of Community Medicine at the University of Pennsylvania School of Medicine, and chairman of the Subcommittee on Mental Health of the Philadelphia County Medical Society. He is a board certified psychiatrist. Robert P. Haigh, of Harrisburg, was named acting deputy commissioner of mental health by DPW Secretary Helene Wohlgemuth.

COUNCIL VOTES TO CHANGE NAME The Council on Public Service at its June 14 meeting voted to approve the report of the Society's new Communication Division and voted to recommend the Council's name be changed to the Council on Professional Relations and Services. Council Chairman Robert N. Moyers, M.D. reported on the Pennsylvania Medical Cooperative membership drive. The cooperative has received national attention in the medical news media and information requests for information have come from medical societies throughout the country.

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Vol 225, No 7

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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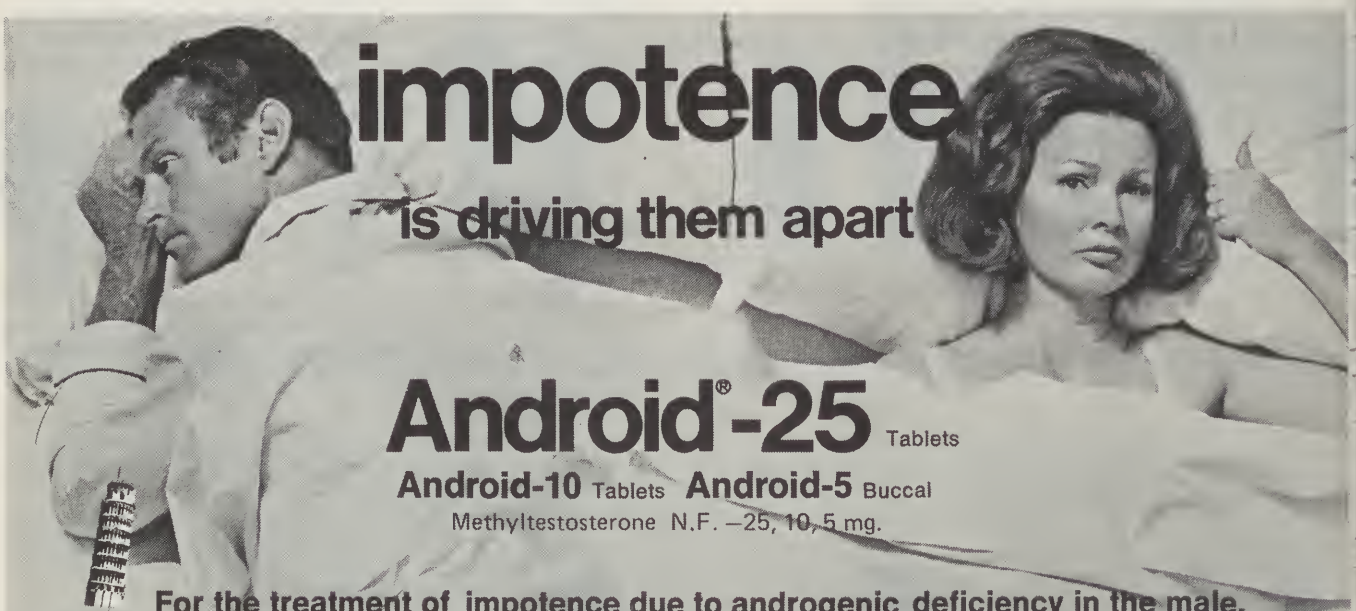

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Methyltestosterone N.F. –25, 10, 5 mg.

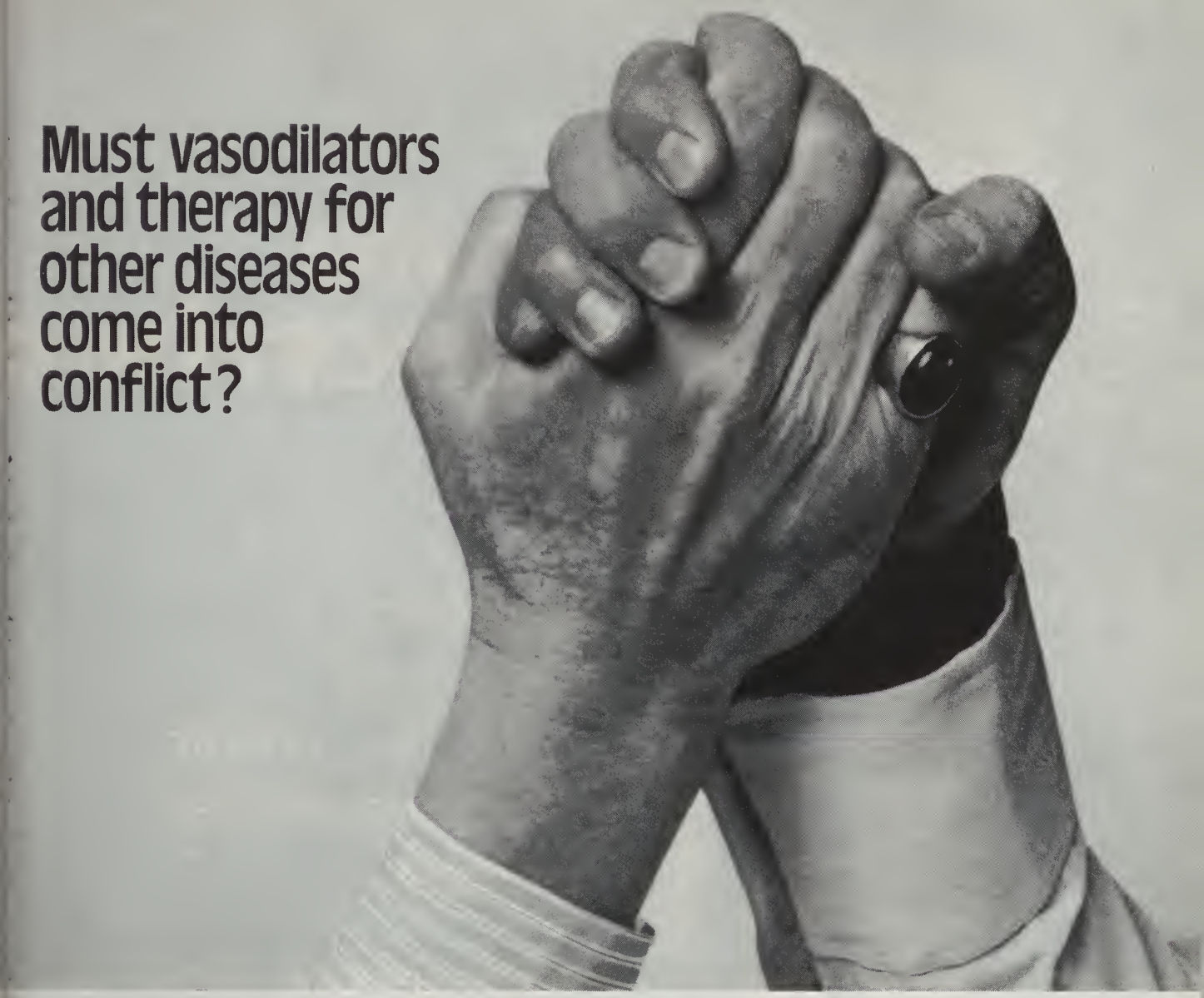
For the treatment of impotence due to androgenic deficiency in the male.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptome when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Posipuberal cryptorchidism with evidence of hypogonadism. Choleetatic hepatitis with jaundice and eltered liver function tests, auch as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function iests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cerdiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervoue, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or euepected carcinoma of the prostaie and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of teeticular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hyperseneitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercaicemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and waier retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requiremenis are best administered in divided doses. The following is suggesied as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. In bottles of 60, 250.

Write for Literature and Samples BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057

REFER TO PDR

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

© 1973 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-1)
The Upjohn Company, Kolomazoo, Michigan 49001

†For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

When a cough spoils your patient's day...

Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Available in 8-oz. Family Size and 4-oz.
No Rx needed—recommend over the phone.

The Adult Expectorant that is great for kids, too.

Dorsey Laboratories/Division of Sandoz-Wander, Inc./Lincoln, Nebraska 68501

BO-SD

Board approves council appointments

President Elect A. Reynolds Crane, M.D., has announced the confirmation by the Pennsylvania Medical Society Board of Trustees and Councilors of members of the Society's four administrative councils for 1974-75. They are:

Council on Governmental Relations—Donald E. Harrop, M.D., Chester County, chairman; Michael P. Levis, M.D., Allegheny County, vice chairman; R. William Alexander, M.D., Berks County; Leonard Bachman, M.D., Philadelphia County; Robert J. Carroll, M.D., Allegheny County; Paul A. Cox, M.D., Cumberland County; Anthony J. Cummings, M.D., Lackawanna County; H. Keith Fischer, M.D., Philadelphia County; J. Preston Hoyle, M.D., Union County; Philip Ingaglio, M.D., Philadelphia County; S. Victor King, M.D., Blair County; Lawrence J. Mellon, Jr., M.D., Delaware County; and Bernard B. Zamostien, M.D., Philadelphia County.

Council on Medical Service—Henry H. Fetterman, M.D., Lehigh County, chairman; William G. Ridgway, M.D., Lancaster County, vice chairman; John J. Danyo, M.D., York County; Wayne W. Helmick, M.D., Beaver County; Webb S. Hersperger, M.D., Cumberland County; Allen H. Holt, M.D., Mercer County; J. Scott Hommer, M.D., Blair County; Matthew Marshall, Jr., M.D., Allegheny County; Stewart McCracken, M.D., Philadelphia County; Robert A. Schein, M.D., Allegheny County; John L. Steigerwalt, M.D., Montgomery County; R. Robert Tyson, M.D., Philadelphia County; and Charles K. Zug, III, M.D. Northampton County.

Council on Public Service—Ulysses E. Watson, M.D., Montgomery County, chairman; James B. Donaldson, M.D., Philadelphia County, vice chairman; William R. A. Boben, M.D., Lancaster County; Stanley N. Cohen, M. D., Philadelphia County; John C. Cwik, M.D., Cambria County; Leo C. Eddinger, M.D., Lehigh County; Lawrence D. Ellis, M.D. Allegheny County; Thaddeus Lekawa, M.D., York County; Robert Poole, M.D., Chester County; John F. Rose, M.D., Montour County; John E. Steele, M.D., Carbon County; G. Winfield Yarnall, M.D., Dauphin County; and David F. Gillium, M.D., Tioga County.

Council on Education and Science—James A. Collins, Jr., M.D., Montour County, chairman; James A. Raub, M.D., Blair County, vice chairman; J. Reed Babcock, M.D., Centre County; William E. DeMuth, M.D., Cumberland County; Paul W. Dishart, M.D., Allegheny County; Frederick D. Fister, M.D., Lehigh County; Frederick B. Glaser, M.D., Philadelphia County; William C. Grasley, M.D., Centre County; Abram M. Hostetter, M.D., Lebanon County; David W. Kistler, M.D., Luzerne County; Roland A. Loeb, M.D., Lancaster County; David G. Moyer, M.D., Montgomery County; Joseph J. Schwerha, M.D., Allegheny County; Bernard Sigel, M.D., Philadelphia County; Nathan Sussman, M.D., Dauphin County; Samuel G. Watterson, M.D., Somerset County; Theodore L. Yarboro, M.D., Mercer County; and Nikitas J. Zervanos, M.D., Lancaster County.

1972 PRA recipients sent council congratulations

A letter of congratulations has been sent to physicians who have received the 1972 AMA Physician's Recognition Award from James A. Collins, Jr., M.D., chairman of the Society's Council on Education and Science.

Enclosed with the letter is a file folder containing space for recording dates of applications made and awards received together with a blue work sheet for recording credits earned toward the next required application. In the case of the 1972 award recipients, this will be in 1975.

The 1975 award will be the first triennial report credited to PMS membership requirement. When the 1975 AMA Physician's Recognition Award application form is received, information from the blue sheet can then be transferred, the application filed with the AMA, and continued membership in PMS will be automatically assured.

Radiologists elect officers

The Pennsylvania Radiological Society, a chapter of the American College of Radiology, elected new officers at its annual meeting at the Hershey Hotel in Hershey recently. They are:

Drs. C. Jules Rominger, Philadelphia, president; Theodore A. Tristan, Harrisburg, president elect; Ross H. Smith, Jr., Pittsburgh, first vice president; Gilbert H. Alexander, Pittsburgh, second vice president; Robert B. Funch, Philadelphia, secretary; and Bernard J. Ostrum, Philadelphia, treasurer.

Federal, state payment programs mesh for chronic kidney disease patients

Final policies for payment of care for patients with chronic kidney diseases have been announced by Caspar Weinberger, secretary of the Department of Health, Education, and Welfare. Federal payment for chronic renal dialysis services began in 1973 on an interim basis under amendments to the medicare sections of the Social Security Act which were a part of Public Law 92-603. Regulations cover establishment of treatment networks, selection of facilities, quality control, and reimbursement of facilities and physicians, all under the jurisdiction of the Department of Health, Education, and Welfare. Local review boards are planned to monitor the appropriateness and utilization of services and are expected to become an integral part of Professional Standards Review Organizations.

The final policies include a new option for paying physicians for their services to kidney patients. If physicians choose, they may be paid a comprehensive monthly fee per patient for providing all necessary medical services. The alternative they may choose is to charge their usual fee for each service, except for the comprehensive care rendered during dialysis treatments, which will be covered by HEW's single reimbursement to the facility where dialysis takes place.

As under the present medicare program, physicians may either bill the patient directly or bill medicare for services on behalf of the patient.

Charles C. Edwards, M.D., assistant secretary for health, said, "We hope that all physicians participating in the program will voluntarily choose to accept assignment of benefits payable by the medicare program as payment."

In Harrisburg, Secretary of Health J. Finton Speller, M.D., announced that Pennsylvania patients suffering from end-stage kidney disease will be helped in paying the deductible and 20 percent coinsurance under the federal medicare plan.

Pennsylvania has been one of the few states which had provided direct aid to chronic renal disease patients prior to the enactment implementation of the medicare amendments. George A. Jones, M.D., director of the Commonwealth's Chronic Renal Disease Services, said, "The decision to reimburse patients for the deductible and 20 percent coinsurance, which they themselves must pay under medicare, coincides with the original concept of the legislature in setting up our program—namely, to provide all the support a Pennsylvania resident needs and cannot obtain elsewhere in order to obtain dialysis treatment."

The state has thirty-five hospitals participating in the program. Patients may be enrolled in the state program by physician referral or direct contact with one of the participating hospitals. In addition the department of health advises they consult the nearest Social Security Administration office for information on how to apply for federal funds through medicare's chronic renal disease program.

Additional information is available by contacting Chronic Renal Disease Services, Pennsylvania Department of Health, P.O. Box 90, Harrisburg, Pa.

Clinic elects new officers

The Wainwright Tumor Clinic Association elected new officers at the forty-fourth annual meeting held in Pittsburgh in May.

They are: Roscoe W. Teahan, M.D., Philadelphia, president; George R. Greenwood, M.D., Bethlehem, president elect; Kenneth K. Meyer, M.D., Sayre, vice president; Alan W. Shriver, M.D., Greensburg, treasurer; and James S. Furnary, M.D., Johnstown, secretary. C. Jules Rominger, M.D., Philadelphia, was elected director, and Roland A. Loeb, M.D., Lancaster, and Lester G. Steppacher, M.D., Philadelphia, were reelected directors.

Membership information may be obtained from Hugh R. Gilmore, Jr., M.D., executive secretary, Box 90, Harrisburg, Pa.

ACS schedules meeting

The American College of Surgeons will hold its annual clinical conference at the Miami Beach Convention Center, Miami, Florida, October 21-25.

Accredited postgraduate courses earning Category One credit on an hour-for-hour basis will number seventeen. There are 260 research reports scheduled, as well as panel discussions, live telecasts of operations from Jackson Memorial Hospital, films of operations and surgical techniques, and scientific exhibits.

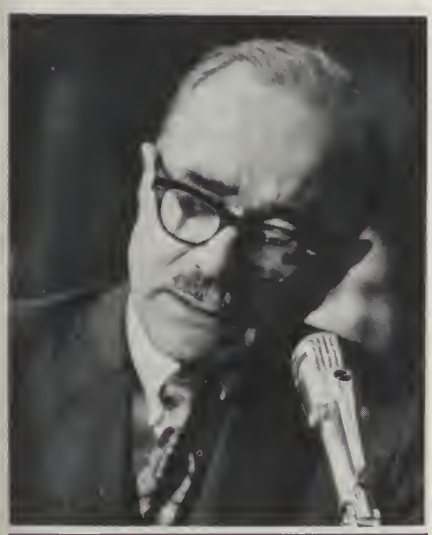
Registration is free to fellows of the college, initiates, candidates, and surgical residents. Others will pay a $90 fee (except federal service physicians for whom the fee is $50). For further information, contact Edwin W. Gerrish, M.D., Assistant Director, Assembly, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

Senate Finance Committee hears Foundation testimony

Calling Professional Standards Review Organization (PSRO) legislation "primarily a waste control and quality assurance measure rather than cost control and benefit limitation legislation," Matthew Marshall, Jr., M.D., president of the Pennsylvania Medical Care Foundation, testified before the U.S. Senate Finance Committee during its PSRO hearings in May.

Dr. Marshall reminded committee members that PSRO has been, and continues to be, supported by the Pennsylvania Medical Society and the Foundation. But, he said, "Physicians and more importantly their patients continue to be progressively frustrated by increasing amounts of red tape interposed in the patient care process by the regulations made and administered by those who apparently do not fully understand the problems of administering health care. A graphic example of this is the 'Waiver of Liability' provision in P.L. 92-603, which we feel is an extraordinarily confusing section. . . We would recommend that this section of the law be repealed or modified."

Dr. Marshall called on the committee to consider potential amendments in the light of strengthening, not weakening, grass roots physician responsibility, concern for confidentiality, and assurance of quality care. He said a broadened mandate to apply PSROs to all health care situations does not seem necessary now, but he added, "We cannot afford an additional wave of inflation in health care costs which will occur if additional health care programs are instituted. . . Assuring the public of the quality and cost effectiveness of its care should have greater national priority than instituting new programs to underwrite the cost of care without effective and appropriate controls."



DR. MARSHALL testifies at hearing.

PRESENT to represent the Pennsylvania Medical Care Foundation at the U.S. Senate Finance Committee hearings on PSRO are (left to right) Henry H. Fetterman, M.D., vice president; Matthew Marshall, Jr., M.D., president; and William F. S. Orner, Jr., coordinator of field services.

Is fake cancer cure spreading?

ROBERT LAMB
Director of Communications

Laetrile, a compound consisting principally of amygdalin, a glucoside obtained from peach and apricot kernels, alleged to control and treat cancer, has been banned by both Canadian and American Food and Drug Authorities.

The U. S. Food and Drug Administration states that "it has seen no competent scientific evidence that laetrile is effective for the treatment of cancer." In Canada, the Food and Drug Directorate succeeded in getting a Superior Court to uphold its ban on the distribution of laetrile. In fact laetrile has been banned as a legitimate cancer treatment drug since the early 1960s. Why then, the sudden notoriety?

This February the Beaver Valley Committee for Freedom of Choice in Cancer Therapy began securing television time in the Pittsburgh area. The committee which espouses laetrile and vitamin B17 therapy is headed by Thomas H. Mansell, a retired steel worker, and Dr. R. M. Hartman, Jr., optometrist and "vision specialist."

The Allegheny County Medical Society under the leadership of its president, David W. Clare, M.D., immediately took action with the print and broadcast media in the Pittsburgh area. Consequently the flurry of activity in early 1974 has subsided.

Dr. Clare has reported, however, that the Beaver Valley Committee for Freedom of Choice in Cancer Therapy is running a two-pronged program. "Not only are they seeking more converts among cancer victims; they are also preparing to press for legislation which would overrule FDA restrictions against the use of laetrile—offering 'freedom of choice' to patient and doctor in the selection of treatment modality." Dr. Clare alerted the State Society in a letter to Leroy A. Gehris, M.D., chairman of the Committee on Quackery.

The Board of Trustees in May called for effective action against proponents of laetrile.

In any campaign against quack remedies, particularly those held out to cancer victims, there is the danger that the attack may also publicize the product.

Physicians can help by being on the lookout for any activity on laetrile in their communities. If any of your patients ask about laetrile or you see any local stories on laetrile or a Committee for Freedom of Choice in Cancer Therapy, please contact L. Riegel Haas, PMS staff man for the Committee on Quackery.

Pennsylvania seven medical schools graduate 883 doctors of medicine

Pennsylvania's seven medical schools graduated 883 new doctors of medicine this spring.

Jefferson

The largest class (189) was graduated by Jefferson Medical College of Thomas Jefferson University at commencement exercises held June 7 at the Academy of Music in Philadelphia. The largest class in Jefferson's history brought their total Doctor of Medicine degrees conferred to 22,234, a national record for any medical school. Twenty-three of the graduates were five-year accelerated students. One of the five honorary degrees conferred went to a Pennsylvania physician, Robert A. Hingson, M.D., professor of anesthesiology at the University of Pittsburgh School of Medicine and Dentistry, who received a Doctor of Science degree. The College of Graduate Studies conferred four Master of Science degrees and the College of Allied Health Services conferred eighteen Bachelor of Science degrees in medical technology.

Temple

Temple University School of Medicine held its commencement exercises on May 29 at the Temple University Music Festival Theater in Ambler. Dr. Charles Papacostas, professor of pharmacology, delivered the address. A total of 165 medical degrees and 150 allied health degrees were presented.

Pennsylvania

The University of Pennsylvania School of Medicine graduated 148 new physicians. General commencement ceremonies for the university were held May 20 at the Philadelphia Civic Center with Governor Milton J. Shapp presenting the address. At the medical school's ceremony, the School of Allied Medical Professions also conferred seventy-six Bachelor of Science degrees—eighteen in medical technology, twenty-four in occupational therapy, and thirty-four in physical therapy.

Hahnemann

Hahnemann Medical College and Hospital awarded 121 Doctor of Medicine degrees at its commencement exercises held at the Academy of Music in Philadelphia on June 6. U.S. Representative Daniel J. Flood addressed the graduating classes. Additional degrees conferred were eight Doctor of Philosophy degrees, twenty-eight Master of Science degrees, twenty-five Bachelor of Science degrees, and sixty-eight Associate in Science degrees.

Medical College of Pennsylvania

Medical College of Pennsylvania (MCP) graduated its largest class to date (seventy-eight) in ceremonies on May 18 at the Irvine Auditorium of the University of Pennsylvania. The commencement speaker was Reneé C. Fox, Ph.D., professor and chairman of the department of sociology at the University of Pennsylvania. Of five honorary degrees conferred, a Doctor of Science degree was awarded to Jonathan E. Rhoads, M.D., professor of surgery at the University of Pennsylvania School of Medicine. Robert Slater, M.D., MCP's new president, presided as his first official act. A new library and the new Peterson Multidisciplinary Teaching Laboratory were dedicated. In separate ceremonies, the Clinical Laboratory graduated eight medical technicians.

Pittsburgh

The University of Pittsburgh School of Medicine held ceremonies in Carnegie Music Hall May 30. Leon Eisenberg, M.D., professor of psychiatry at Harvard University, delivered the address. Pitt's largest class to date graduated 119 Doctors of Medicine and awarded six M.S. and seven Ph.D. degrees. The School of Health Related Professions conferred 105 Bachelor of Science degrees, ten Bachelor of Science degrees in health related professions, and twelve Master of Science degrees.

Hershey

Milton S. Hershey Medical Center, Pennsylvania State University, Pennsylvania's newest medical school, graduated sixty-three M.D.s at its fourth commencement on May 25 at Founders Hall at the Milton Hershey School. John W. Oswald, Ph.D., Pennsylvania State University president, was the speaker, and Harry Prystowsky, M.D., provost and dean of the medical school, presented the M.D. candidates. This year's class brings to 200 the number of physicians graduated at Hershey. Twenty-one of the graduates have accepted residencies in Pennsylvania (nine of them at Hershey) and 79 percent of the class will do residency work in primary care including 33 percent in family medicine. One Doctor of Philosophy and seven Master of Science degrees were conferred in basic medical sciences.

Allergy society installs

The Philadelphia Allergy Society elected officers for 1974-75 at a recent spring meeting. They are: Irving H. Itkin, M.D., Philadelphia, president; George A. Moll, M.D., Jenkintown, vice president; and Charles G. Blumenstein, Jenkintown, who was re-elected secretary-treasurer.

Under freedom of information decision

Medicare charges public information

A recent court decision concerning the Freedom of Information Act provides that all medicare Level II charges now are considered public information and are available from medicare carriers upon request. Prior to this determination, medicare provider information, including physicians' profiles, was the closely guarded property of the Social Security Administration.

It is important to understand what information is now available and what information is still considered to be confidential. Basic to this is an understanding of the terminology which is used under the medicare program as well as that used by the carrier. Under the law, just before the beginning of each fiscal year (July 1), medicare reviews the actual charges billed by physicians in the preceding calendar year. The most frequently billed actual charge by a doctor or supplier for a service or an item is established as his *customary* charge for that service. The *prevailing* charge is then established as the range of all individual doctor's or supplier's customary charges for each service in a particular specialty in a given geographic area. In effect, the prevailing charge for any given service or item is the amount which is high enough to cover in full the customary charges of those doctors or suppliers whose billings account for at least 75 percent of all claims for that service or item in the locality in the preceding year.

In view of the fact that the definition of this payment criterion under Blue Shield's Prevailing Fee Program differs from medicare terminology, we refer here to Level I and Level II charges to avoid unnecessary confusion. Simply stated, Level I charges relate to an individual physician's personal profile, while Level II charges are the ceiling or 75th percentile level which is determined from the aggregate of physicians' Level I charges. An individual physician may upon request, secure the Level II charges of any specialty in any or all of four charge/class areas of Pennsylvania. These charge/class areas or socio-economic divisions of Pennsylvania can account for a significant differential of payments within a specialty for an identical procedure.

Any physician who desires to have Medicare Level II information should write to: Robert W. Fraser, Director of Communications, Pennsylvania Blue Shield, Camp Hill, Pennsylvania 17011. Requests must be in writing and must clearly indicate the specialty or specialties, as well as the area or areas desired. No charge will be made for requests up to ten pages in length. However, a charge of 25 cents per page for more lengthy requests will be made.

X-ray standards revised

New extensively revised and amended federal standards for diagnostic x-ray equipment become effective August 1, 1974, and will affect not only manufacturers and assemblers, but also users.

One of the principal protection provisions of the standard requires machines to restrict the x-ray beam to the size of the film or fluoroscopic image receptor. There are also provisions intended to make it possible to reproduce more consistently a given image quality for given voltage, current, and time settings. This capability, in combination with good x-ray examination techniques, will minimize film retakes and unnecessary exposure.

The FDA is conducting a series of one-day workshops to familiarize persons installing x-ray equipment with the new regulations. They will also cover proposed federal requirements involving the resale of used x-ray equipment.

For further information on the regulations or the workshops, Pennsylvanians should contact Henry Kocol, Region III, 1204 U.S. Customhouse, Room 902B, Second and Chestnut Sts., Philadelphia 19106. Telephone: (215) 597-4506.

Philadelphia receives grant

A two-year, $390,248 grant from the Robert Wood Johnson Foundation for an improved medical communications and transportation system for the Philadelphia area has been awarded to the Philadelphia Health Management Corporation.

The corporation will subcontract certain areas to the City of Philadelphia—which has already marked funds for five mobile intensive care units for the Fire Rescue Squad.

The remainder is earmarked for improving communications both within city departments and between the city facilities and Philadelphia hospitals. Provision has been made for voice contact with hospitals and for an electronic telemetry system.

The plan which was prepared by the combined efforts of city departments, the Health Management Corporation, and the Center for the Study of Emergency Health Services at the University of Pennsylvania, was one of forty-four in the nation selected to share in a total $15 million from the Johnson Foundation.

Medical staff proceedings privileged

DANIEL J. MENNITI, ESQ. FRED SPEAKER, ESQ.
Harrisburg

On January 31, 1974, the Supreme Court of Nebraska rendered a decision in a case concerning the confidentiality of proceedings and records of medical staff committee meetings. The decision is important in these days when the right to privacy and confidentiality are still being strongly litigated. The conclusion of the Court was that " . . . the proceedings and records of the medical staff committee of the defendant hospital were privileged . . . . " *Oviatt v. Archbishop Bergan Mercy Hospital,* 214 N.W. 2d 490 (Neb. 1974).

The case involved an action against the hospital by a patient who alleged that a physician who had participated in an operation for a hysterectomy on her was the cause of damage to her sciatic nerve. By discovery procedures the patient had obtained copies of the records of the hospital relating to the restriction or suspension of the physician's staff privileges at the hospital prior to the date of her hysterectomy. The defendant physician had filed a motion to prevent "the plaintiff from using or referring to any proceedings, minutes, records or reports of the medical staff committee of the defendant because the documents were privileged."

The trial court sustained the motion, and on appeal the Nebraska Supreme Court upheld the action of the trial court.

One basis for the decision of the Nebraska Supreme Court was the presence of a statute in Nebraska which provided that the proceedings, minutes, records, and reports of medical staff committees and utilization review committees together with all communications originating in such committees were to be privileged and not subject to discovery unless the privilege is waived by the patient and a court of record orders their disclosure after a hearing at which good cause arising from extraordinary circumstances is shown. The court, however, also relied on a District of Columbia case, [*Bredice v. Doctors Hospital, Inc.*, 50 F.R.D.249 (D.D.C. 1970)] and quoted the latter case at length to explain the purpose of privilege statutes. The latter case held that privilege was a prerequisite to adequate hospital care because it permitted candid and conscientious evaluation of the hospital's clinical practices. Moreover, the constructive professional criticism could not occur, the court said, if it were available to a patient to use in a malpractice suit. Therefore, the court held on the basis of the Nebraska statute and reasoning of the District of Columbia case that the trial court had acted properly. The *Bredice* case, parenthetically, held that the minutes and reports of any board or committee concerning the death of the patient were held to be privileged from discovery; this was in the District of Columbia where there is no statute similar to that in Nebraska.

He keeps blaming his high blood pressure on the state income tax!

The Nebraska Supreme Court further held that there was no proof that the hospital knew facts which would have caused it to revoke the physician's privileges before the date of the hysterectomy. Moreover, it was necessary for the plaintiff to prove that the proximate cause of her injury was something which the physician, whose work was discussed in the committee meetings, did or failed to do while assisting in the operation.

The case is important, especially in view of the reasoning involved in upholding the confidentiality of medical staff committee and utilization review committee meetings. Usually in Pennsylvania the records of the medical staff committee meetings are subject to discovery and are admitted into evidence, as are other records made in the ordinary course of business. It seems, however, that in federal courts, as was evidenced in the *Bredice* case, the confidentiality of records might be upheld on the basis of privilege.

Let George say it!

Sometimes your worst enemies are right at home

GEORGE A. ROWLAND, M.D.
Millville

Everybody criticizes organized medicine. Newspaper columnists refer to the AMA as one of the most powerful unions, and many less informed people believe that medicine has an inside track to high places in government. The average physician, on the other hand, believes that the bottom figure on the totem pole carries the stethoscope. He also feels that his state and national organizations care little for his problems and are totally impotent in helping him.

The truth actually lies somewhere in between. Medicine faces many bitter antagonists who are ready to oppose any AMA position. By trial and error organized medicine has learned a great deal about how democratic government works. Although medicine truly has no hotline to high places, it does have some very experienced and capable members and employees who have learned to know legislatures and legislators. These persons, having established themselves as honest and hardworking, are often able to present medicine's point of view effectively to law making bodies. By applying time tested methods of rationality and compromise, their efforts have been responsible for much good medical legislation and have prevented the passage of many measures that would have been seriously detrimental to the nation's health.

With this preamble it is in order to recount a story. Recently a bill was introduced into the Pennsylvania Legislature which would have expanded the scope of the practice of optometry in the Commonwealth. It would have given optometrists the right to use local anesthetics, cycloplegics, and mydriatics under certain circumstances. As it happened this was strongly supported by some legislators who had been generally friendly to the interests of the Pennsylvania Medical Society. Through its regular channels the Society was alerted to the new bill. The undesirable features were recognized, and arrangements were made to watch its progress and take appropriate actions as might become necessary.

Unfortunately, the Pennsylvania Academy of Ophthalmology and Otolaryngology also became aware of the bill about this time. Enraged that such a measure could even have been introduced, its leaders demanded that all-out action be taken to prevent its passage. Telephone calls and correspondence with PMS officers were vitriolic as the society was urged to set aside all other priorities and fight this bill in every possible way. This extreme agitation was even carried to the floor of the Society's House of Delegates. Vehemence and invective convinced the delegates that this matter deserved the support of all physicians. The resultant action directed the Board and legislative representatives on this issue to maintain a stone wall type of defense with no compromise.

A misconception often held by people who are unfamiliar with the democratic process is that any purpose can be gained by those who are sufficiently determined simply by talking loudly and applying power. Such an approach works in military situations if the forces necessary are available. It is not appropriate where votes are required to attain a given end. Votes can be garnered from generally uninterested assemblymen only by promising something in return. Strongly worded statements and personal attacks more often lead to antagonism than to cooperation.

A legislator is influenced by measures which have strong popular support since these will have an influence on whether he is returned to office at the next election. In this case, the ophthalmologists, almost entirely centered in the large cities of our state, were in a poor situation to get popular support since most of the people of the Commonwealth receive their visual care from optometrists. The battle plan forced upon the Pennsylvania Medical Society was to demand a rather unpopular action from the General Assembly with no leverage, neither a carrot nor a stick to attract the necessary votes.

There persists a feeling among many physicians that some features of this bill could have been accepted. The bill's supporters certainly expected to consider compromises, but there was now no choice as to procedure. Members of the legislature were surprised by our unyielding position.

Dr. Rowland is a member of the State Society Board of Trustees, chairman of its Finance Committee, and a PMS delegate to the AMA. He is active also in the American Academy of Family Physicians.

The problem was further aggravated by some critical correspondence addressed to assemblymen by leaders of the campaign. Legislators found extremely offensive personal criticisms of ranking assemblymen whose motives and honesty were impugned. The deluge of letters antagonized reasonable men and lost votes.

The position of organized medicine was further worsened when the newspapers of Philadelphia suddenly broke the story that an ophthalmologist was fired from his position on the faculty of one of the medical schools because of his position on the bill. Altogether the picture of medicine as a self-interested group with very little concern for the public good was encouraged.

The unfortunate outcome that many of the Society's experts predicted has now taken place. The original bill with all the objectionable features originally presented and opposed so adamantly by the PMS has now become law. This outcome did not have to happen. Life with no room for compromise can be a very hard, bare type of existence. As my grandmother used to say, "If you don't bend, you'll have to break." The PMS legislative efforts broke on this issue. The pieces will be lying around to be picked up for a good while.

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JOSEPH V. MORTON
Director, Bureau of Drug Control

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● That the Federal Drug Enforcement Administration, through an independent research organization, has found that seventy-two percent of Dilaudid abuse throughout the *nation* is traceable to the Philadelphia area?

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AT THE annual dinner meeting of the Delaware County Medical Society, the photograph to the left shows John L. Kelly, M.D., county society president,as he accepts the gavel from outgoing president, David L. Mudrick, M.D. In the photo on the right, F. Peter Kohler, M.D., society secretary, presents the President's Bowl to Dr. Mudrick in appreciation of his service.

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envisio would fill a definite need for the pract ing physician. Suc compendium wou give him all th information ne essary for usi a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

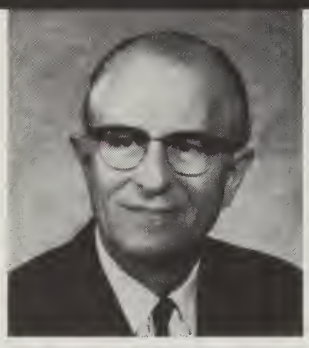
What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactio with other drugs.

The information would be based on the package insert and have the same legal status. In fa a complete compendium with co plete and current information might even eliminate the necess

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, I believe, be private, not federal, i sponsorship. They should contai comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every ye

Function of a Compendium

A compendium should furnish the following information o drugs in the following order: indi tions for use, side effects, adver drug reactions, contraindication drug interactions, drug dosage a the dosage forms marketed. Dru prices should not be included be cause they vary so widely and change rapidly.

No compendium should se forth drugs of choice or discuss relative efficacy. Such question must be left for the practicing p sician to decide, whether on the basis of the medical literature, h own clinical experience, advice colleagues, information supplie by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor how to use drugs. Rather, it mus be a reference source designed marily to refresh his memory as drugs he may not use regularly.

r a package insert in many in-
nances. This would constitute a
bstantial saving for the manu-
cturer.

By a complete compendium,
o not mean a volume of prohibi-
e size. You don't need a book
scribing 25,000 products with
enormous amount of repetition.
ther, drugs should be arranged
class. Mutually applicable infor-
ation would be provided, along
th brief discussions pinpointing
fferences in specific drugs of
at class. Listings would be cross-
dexed in a useful way.

her Available Documents as urces of Information

Existing references such as R and the AMA Drug Evaluation e obviously useful but they are complete. Either they are not ss-referenced by generic name d do not group drugs with simi- characteristics, or they do not all the available and legally rketed drugs. And some of se omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

uld in no way imply control over
e practitioner's prerogatives.

y Another Compendium?

A practicable, single-volume
mpendium cannot, nor is it
cessary to, include all drugs on
e market today. From my prac-
e of internal medicine for some
years, my experience as a con-
tant, and as a faculty member
four or five medical schools, I
uld estimate that a doctor uses
ly 30 to 35 drugs regularly. The
72 Physicians' Desk Reference,
cidentally, contained about
500 entries.

As to whether there should be
ederal compendium, in my opin-
n, as stated earlier, the answer is
sy—there should *not* be one. The
posal assumes that existing
mpendia are inadequate. We're
t sure of that at all. Whatever its
perfections, the present drug
ormation system in the U.S. is
en, multifaceted, pluralistic and
ensive. Good compendia exist,
well as other ample sources on
g therapy, ranging from journal
erature through AMA Drug Evalu-
on to company materials. Not
physicians may use such
urces as often or as well as they
uld, but that is the fault of the
an, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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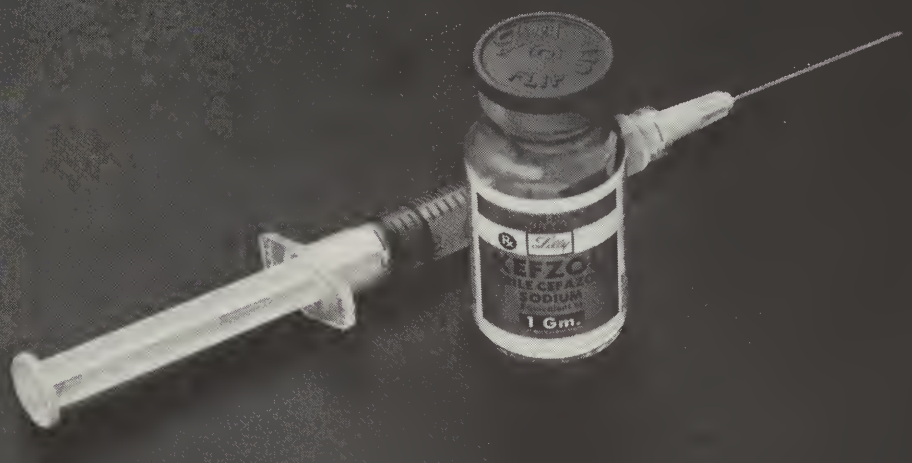

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editorials

Informed consent—historic dilemma

"Forasmuch as the law of God . . . allows no man to touch the life or limb of any person except in a judicial way, be it hereby ordered and decreed, that no physicians . . . shall presume to exercise or put forth any act contrary to the known rules of art nor exercise any force . . . without the advice and consent of such as are skillful in the same art, if such may be had, or at least the wisest and gravest then present, and consent of the patient or patients (if they be mentally competent) much less contrary to such advice and consent, *upon such punishment as the nature of the fact deserve;"*

As early as May 3, 1649, the settlers of Massachusetts Bay were concerned about informed consent and so wrote a protective clause into the first medical practice law of the colonies. Today there is just as much concern and probably more controversy surrounding this nebulous entity. Informed consent is that consent given for a treatment or procedure after all consequences and risks involved are clearly understood. Treatment without consent is assault and uninformed consent is no consent at all. A patient is entitled to facts concerning the disposition of his case. It is the duty of the physician to see that the patient possesses enough material facts to make a decision.

The physician's duty to inform was, in the past, determined largely by the standard practices of the medical profession in his own community. In three separate interpretations of informed consent cases by the Supreme Courts of California and Rhode Island and the federal appellate court of the District of Columbia, the decisions handed down reversed the standards. These courts ruled that it is not the medical profession's normal practice that should determine the scope of disclosure. Enough material information must be imparted so that the patient can make an intelligent decision. The extent of the disclosure should be geared to the patient's needs.

Increasingly, informed consent cases are being treated on individual merit. It would be well for physicians to keep the following in mind when preparing a patient for treatment.

If disability is a hazard of a procedure, no matter how small the risk, the patient should be informed. Some patients would rather submit to a less effective method of treatment than risk the consequences of permanent disability.

Blanket hospital consent forms are of negligible value. Consent given on these forms is not informed because alternative treatments and risks of procedures are not included.

The physician should make detailed progress notes on the patient's medical chart documenting all discussion with a patient regarding a procedure and any significant reactions on the part of the patient. If the patient chooses not to be informed of risks inherent to a procedure, this should also be noted on the chart.

Never guarantee results. Purely therapeutic affirmations may be misconstrued as a guarantee by the patient.

The law demands that disclosure be based on the application of the reasonable man standard rather than the reasonable physician. Be sure the patient understands exactly what you wish to do, the risks involved, alternate routes, and the results of nontreatment.

David A. Smith, M.D.
Medical Editor

We can handle the tune-up, Doc, but we're gonna have to call a PCV man in for the emission system. . . .

M.D.s in the news

Richard Naeye, M.D., chairman of pathology at the Milton S. Hershey Medical Center, Pennsylvania State University, reported his findings on sudden infant death syndrome at a recent meeting of the National Institutes of Health. Chronic low oxygen exposure and the persistence of newborn fat around the adrenal glands are two of his research discoveries.

Stuart I. Brown, M.D., has been named chairman of the department of ophthalmology both at the University of Pittsburgh School of Medicine and at the Eye and Ear Hospital of Pittsburgh. Dr. Brown was previously clinical associate professor and director of the Cornea Research Center at New York Hospital-Cornell University Medical Center. He has done extensive research in corneal problems and clinical work in corneal transplantation.

Ruben Tenicela, M.D., associate professor of clinical anesthesiology at the University of Pittsburgh School of Medicine, spoke on acupuncture at a recent meeting at the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey.

Thomas W. Lanfitt, M.D., has assumed the permanent post of vice president for health affairs at the University of Pennsylvania. He is Charles Harrison Frazier Professor of Neurosurgery and director of the division of neurosurgery at the Hospital of the University of Pennsylvania.

AT A RECENT meeting of the Northumberland County Medical Society, a PMS Fifty-Year Award was presented to Victor J. Baluta, M.D., Shamokin, by D. R. Mychak, M.D., society president. Also present were William J. Rumberger, D.D.S. (far left), and Mrs. Rumberger, son in law and daughter of the honored physician.

DR. LANFITT

DR. HERBUT

Peter A. Herbut, M.D., president of Thomas Jefferson University, has been awarded an honorary doctor of science degree by Washington and Jefferson College. Dr. Herbut is a nationally recognized pathologist and the author of four textbooks in his specialty. He had been chairman of the department of pathology for eighteen years prior to assuming the presidency in 1966.

Roger Lester, M.D., has been named professor of medicine and head of the division of gastroenterology at the University of Pittsburgh School of Medicine. He was formerly professor of medicine at Boston University. He is a member of the American Gastroenterological Association, the American Physiological Society, and the American Society for Clinical Investigation.

Frederick B. Glaser, M.D., Bala Cynwyd, has received a Robert Wood Johnson Health Policy Fellowship for a year's study in Washington, D.C. Dr. Glaser is associate professor of psychiatry at Medical College of Pennsylvania and chief of the section on drug and alcohol abuse at Eastern Pennsylvania Psychiatric Institute. He will work with the Institute of Medicine (studying major emerging issues of health policy) and with the Congressional Fellowships Program of the American Political Science Association.

Mayer A. Green, M.D., Pittsburgh, recently attended the annual congress of the American College of Allergists in Paris, France, where he chaired a scientific session and co-chaired an allergy panel. He also attended the college's postconvention seminar in Costa Del Sol, Spain, where he participated in a panel discussion on Cromolyn in allergy and chaired a medical seminar.

A completely volunteer production, based on Martin and Rowan's LAUGH-IN and presented by the Auxiliary of the Montour Medical Society in April, earned over $2,400 for the benefit of the Danville Area Student Loan Fund and Health Career Scholarship. Among the cast of eighty-three persons were over twenty-five physicians including the chief of staff, the assistant chief of staff, the medical director, and three department chiefs at Geisinger Medical Center. Several hospital administrators and two department heads added their talents. The list of physician participants included: **Drs. E. R. Browneller, Gerald Cohn, Robert Burns, James Curtis, Roger Rodgers,** and **Vincent Varano,** who joined in the orchestration. Members of the light-hearted cast included **Drs. Fred Brown, Bill Gibson, John Fazekas, Paul Ferguson, Claude Williams, Fred Jones, Dave Brill, R. French Dickey, John Malcolm, Harry Klinger, Leonard Bush, Jack Rose, Henry Hood, Pete Snyder, W. H. Jeffreys, Marty Lee, Harry Stamey, Jim Collins, Joe Mowad,** and **Ken Quickel.**

RED LION physician, Woodrow S. Dellinger, M.D., is shown in his study which houses some of the Abraham Lincoln artifacts and memorabilia he has collected. Dr. Dellinger was recently honored as a distinguished alumnus by the Lebanon Valley College at its Alumni Day ceremonies. He is a trustee of the college and a Lincoln authority and lecturer.

Benjamin A. Maldonado, M.D., chief of obstetrics and gynecology at Grove City Hospital, has become a fellow of the American College of Obstetricians and Gynecologists. He is a diplomate of the American Board of Obstetrics and Gynecology.

Arthur H. Hayes, M.D., chief of clinical pharmacology at the Milton S. Hershey Medical Center, Pennsylvania State University, was recently elected a fellow of the Royal Society of Medicine in London, England.

Myron Yanoff, M.D., who was chairman of the pathology section of the Association for Research in Vision and Ophthalmology meeting in Florida recently, has been awarded a training grant in ophthalmic pathology from the National Eye Institute.

John Reichel, Jr., M.D., Bryn Mawr, has been appointed chief of ophthalmology at Bryn Mawr Hospital.

P. Robb McDonald, M.D., has been named Philadelphia "Man of the Year" by the Fight for Sight Society.

James B. Snow, M.D., Philadelphia, was elected second vice president of the American Academy of Ophthalmology and Otolaryngology at a recent meeting of the academy.

Cyril H. Wecht, M.D., Pittsburgh, is the recipient of an Honorary Life Membership award from the American Society of Law and Medicine, Inc. for outstanding achievement in medico-legal education. He delivered the keynote address at the society's annual meeting in Boston, Mass., recently.

Ethel Weinberg, M.D., Wynnewood, has been appointed to a four-year term to the Board of Regents of the National Library of Medicine by President Nixon. She is associate dean at the Medical College of Pennsylvania. The Board advises and makes recommendations to the Surgeon General on library policy.

The Strittmatter Award, the Philadelphia County Medical Society's highest honor, has been presented to **Katharine R. Sturgis, M.D.,** in recognition of her achievements as an outstanding physician and teacher. Other awards presented at a May dinner of the society were the first annual "Practitioner of the Year Award," which went to **Bernard B. Zamostein, M.D.,** and the Kenneth Appel Award to **Jean H. Burt, M.D.,** a psychiatric resident at St. Christopher's Hospital. Fifty year service awards were given to thirty-two physicians.

The American Academy of Occupational Medicine recently installed **Bartram D. Dinman, M.D.,** as president. Dr. Dinman is medical director for the Aluminum Company of America in Pittsburgh.

Edmund B. Spaeth, M.D., Philadelphia, has been honored by having the Spaeth Oculo-Plastics department named after him by the Wills Eye Hospital.

MARILYN SOHN MAHON, M.D. (left) president of the medical and dental staff of Harrisburg Polyclinic Hospital, holds this year's Commonwealth Citation of the Board of the Medical College of Pennsylvania, which was presented to her by Sarah Ann Stauffer, (center) Rohrerstown, Board president, as Mrs. John Farr Simons, Germantown, chairman of the 1974 awards committee, looks on. Dr. Mahon, an assistant in the department of obstetrics and gynecology and the department of family practice, has done extensive community work in the areas of abortion, sex education, and venereal disease.

a series of papers on hypertension

hypertension

JOHN H. MOYER, M.D., D. Sc.
Philadelphia

In the spring of 1972 the United States Secretary of Health, Education, and Welfare announced that a nation-wide program would be developed to identify and treat the maximum number of patients with hypertension through education of the public as well as of health professionals. The Hypertension Information and Education Advisory Committee was appointed. In announcing the plan, the secretary noted that hypertension may cause the deaths of as many as 60,000 Americans each year and that it plays a major role in deaths from stroke and heart attacks. It is further estimated that approximately 25 million Americans have hypertension but that less than half of these have been identified.

Subsequently, the Board of Trustees of the American Medical Association approved the appointment of a special Advisory Committee on Hypertension to assist in the development of a program which would be coordinated with federal activities. The committee urges all physicians to cooperate fully in a national program to combat hypertension. The AMA committee has based its conclusions on available statistics which indicate that because of the number of persons with essential hypertension and because the benefits of treatment are so significant, vigorous treatment should be started without delay when hypertension is diagnosed.

In order to facilitate detection of the disease, the committee also encouraged all physicians, regardless of their specialty, to routinely measure the blood pressure of every patient seeking care for any complaint. The National Medical Association has taken similar steps. Persons whose diastolic pressures are found initially to be 105 mm Hg or higher should receive antihypertensive medication and should be followed on a regular basis. If the diastolic pressure averages 90 to 104 mm Hg, the need for therapy should be judged in the light of other clinical factors. Those for whom drug therapy is not thought to be indicated should be advised to have regular follow-up examinations.

The various committees note that an adequate decrease of relatively slight elevations of blood pressure may be obtained simply by treatment with an oral diuretic. Patients who do not respond to the diuretic drug alone, as well as those with greatly elevated initial blood pressures, may require additional drugs given concurrently for adequate control. Specific recommendations on drugs, drug combinations, and dosages for the treatment of hypertension are found in this symposium.

A major consideration in maintaining long-term blood pressure control is continued antihypertensive medication. This can be accomplished by: (1) Educating the patient to the necessity of lifetime observation and treatment, even though he may be asymptomatic. The importance of daily medication must be stressed, and the patient must realize that the risks of untreated hypertension—particularly stroke, heart failure, and renal failure—are markedly reduced by long-term medication. Much of this patient education can be accomplished by the physician's office personnel; (2) Developing a systematic office procedure and plan for the

overview

LEONARD BACHMAN, M.D.
Harrisburg

hypertensive patient. This not only improves patient compliance but also materially reduces physician time and allows the physician to make maximum use of allied health personnel for continuing, long-term management. The systematic selection of drugs in a step-wise treatment plan, avoiding excessively potent drugs or combinations of drugs, will help to avoid unpleasant side effects.

The first phase of this effort—detection of hypertension—can be carried out in multiphasic screening programs, paramedical care programs, routine physician medical care activities, and other industrial and public services. Here, too, allied health personnel should be employed as effectively as possible.

Community Organizations

Subsequent to the announcement of the national plan, a cooperative venture of the private and public sectors was combined with government representation in Eastern Pennsylvania in order to develop a community program for identification and treatment of all patients with high blood pressure known as the Eastern Pennsylvania High Blood Pressure Education Program. It is anticipated that the organizational format will extend so as to include the remainder of the state.

The Governor's Task Force

The state has recognized that there is a need for consumer education on the hazards of hypertension and on the necessity for early medical attention. There is also the need to furnish health care providers with more complete information on the disease and its current treatment method. Governor Shapp has appointed a Task Force on Hypertension to review and study these problems and to recommend positive action that the state can take in cooperation with private and voluntary agencies.

The task force is composed of both consumers and providers. At the first meeting last March, the group decided to break into two working subcommittees, one on professional education and one on consumer education, in order to better concentrate discussion and investigation. The task force will meet periodically during the coming months and will present its final report to the governor for review and implementation.

The Symposium

It is important that a systematic diagnostic and therapeutic program be developed. Once committed to drug therapy, the patient should remain in continuous drug therapy thereafter. The initial therapeutic approach is to give diuretics followed by the sequential employment of small to increasingly larger doses. Less potent drugs proceeding to the more potent agents should be used until the blood pressure is within normotensive ranges. The most simple program for each patient is indicated.

Probably the most significant advance in therapy has been in the treatment of the patient with malignant hypertension. Some advancement since 1957 has been in the development of potent drugs,

but by far the most significant contribution has been in the availability of drugs which are easier to use and which have fewer side effects. As a result, the physician has used these potent drugs more liberally and more effectively.

In the case of hypertensive emergencies, each syndrome requires different drugs or drug combinations. A major advancement has been the recent release of diazoxide (Hyperstat,® Schering Corp.) which must be given parenterally but is a very potent drug for most hypertensive emergencies. Obviously the ideal is for early and effective treatment so as to avoid the necessity of treating the patient as a hypertensive emergency.

In the case of renal artery occlusive disease, the question of etiology is raised. Is this a disease entity or does this complication occur as an atherosclerotic complication of hypertension? The latter seems probable since when the occlusion lesion is corrected by surgery, only about one-third of the patients become normotensive postoperatively, about an additional one-third obtain partial return to the normotensive state, and one-third do not respond at all. This suggests that only about one-third of the patients have true so-called "Goldblatt kidney" and the remaining two-thirds have essential hypertension (one-half having had an additional increase in blood pressure of renal origin due to the occlusion lesion, and in the other half the renal lesion has had very little if anything to do with the blood pressure rise.)

Anticipated Effect of Treatment

Epidemiologic studies in hypertension indicate that morbidity and mortality are directly related to the level of blood pressure. Actuarial data show that in men between the ages of thirty-five and forty-five years, the twenty-year mortality rate is five times higher in individuals with a blood pressure of 160/100 mm Hg than in those with a blood pressure below 140/90 mm Hg. The Framingham studies indicate that the risk in patients with even a modest elevation of blood pressure is six times greater than in the normotensive population for congestive heart failure, three to five times greater for stroke, and two to three times greater for fatal heart attack. Life expectancy is progressively shortened the higher the level of blood pressure.

How effective are antihypertensive drugs in the prevention of this excess morbidity and mortality? A controlled therapeutic trial was carried out by the Veterans Administration in 380 men with initial diastolic blood pressures of 90 to 114 mm Hg. The results of this study indicated that the risk of developing a major cardiovascular complication over a five-year period was reduced from 55 to 18 percent by treatment with antihypertensive drugs. Treatment was beneficial regardless of age but was more effective in patients with initial diastolic blood pressures of 105 to 114 mm Hg than in those with initial pressures of 90 to 114 mm Hg. However, the period of observation may not have been long enough to detect a statistically significant difference in the latter group. Antihypertensive drug treatment appears to be most effective in reducing the incidence of congestive heart failure, stroke (particularly hemorrhagic stroke), renal failure, accelerated or malignant hypertension, and dissecting aneurysm. It is less effective in reducing the incidence of myocardial infarction. However, evidence from several sources indicates that treatment reduces the risk of fatal myocardial infarction.

Although the VA trial was limited to men, other evidence suggests that women with similar elevations of diastolic blood pressure also should be treated. For patients whose diastolic blood pressures average less than 105 mm Hg, the benefits of treatment must be weighed against the possible untoward effects, expense, and inconvenience of life-long drug treatment. This decision is made by evaluating other risk factors present in each patient. Factors that should be considered when electing to treat patients with diastolic blood pressures averaging 90 to 104 mm Hg on three successive office visits include the following: target organ damage (fundi, electrocardiogram, proteinuria), male sex, age under 50, black, family member with major hypertensive complication, presence of hypercholesterolemia or diabetes mellitus, cigarette smoking, and all three diastolic measurements at 95 or more.

Prior to beginning a course of life-long treatment, the patient with mildly to moderately elevated blood pressure should be seen on at least three separate visits to determine whether the blood pressure is persistently elevated. The extent of organic changes, particularly those affecting the optic fundi, brain, heart, and kidneys, should also be assessed. The objective of treatment is to lower the blood pressure to normal or to the lowest level that the patient will tolerate. Usually, a diastolic pressure of 90 mm Hg or lower in the standing position may be achieved without significant untoward effects. When this is accomplished, longevity should be similar to the patient without hypertension.

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Hypertensive emergencies

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THE hypertensive crisis associated with various hypertensive syndromes is by definition a state wherein the blood pressure is severely elevated with diastolic levels usually above 140 mm Hg together with evidence of target organ dysfunction. The clinical manifestations reflect the site of predominant involvement and include encephalopathy, cerebrovascular hemorrhage, and acute oliguric renal failure.[1-6] Also, in the patient with impaired myocardial function, left ventricular failure may be precipitated. Rarely the hypertensive crisis may be dominated by the development of a microangiopathic hemolytic anemia.[7-11] The characteristics of the accelerated phase of hypertension were delineated by Volhard and Fahr in 1914 and included (in addition to the severe fixed hypertension) the presence of advanced retinopathy and a severe impairment of renal function, a rapidly progressive clinical course terminating usually with death in uremia and histologically by the presence of a diffuse necrotising arteriolitis affecting the kidney.[12] These criteria are still valid today.[13-19] The hypertensive crisis is considered a medical emergency[20] and warrants immediate and effective lowering of the blood pressure in an effort to prevent further arteriolar deterioration in vital perfusion areas. There is evidence, furthermore, that with a sustained lowering of the blood pressure, healing of the acute arteriolitis occurs with a return of function to the organs involved. This was first demonstrated conclusively in regard to renal function by Moyer and associates[16] and has subsequently been confirmed by others.[21-24]

This review attempts to outline the pathophysiologies of the hypertensive crises and to discuss the rationale of therapy.

Acute Left Ventricular Failure

The onset of acute left ventricular failure in the course of accelerated hypertension reflects the inability of the ventricular pump to sustain the increased work load. The ventricle responds to an increasing systemic resistance by elevating intraventricular pressure in order to maintain a normal stroke volume at a steady ejection rate. Left ventricular wall tension (intraventricular pressure x radius) is an accepted determinant of myocardial oxygen consumption.[25] The increased systemic vascular resistance engenders a greater increase in intraventricular pressure for a given decrement in ventricular size. The resulting elevation of wall tension reflects an increasing myocardial oxygen consumption. The onset of ventricular dilatation indicates that the pump is functioning on the descending phase of the Frank-Starling system. Moreover, since the radius of the chamber is decreased less for a given stroke volume, wall tension and myocardial oxygen consumption are increased further. The failing ventricle demonstrates a rise in end-diastolic fiber length, an increased ventricular volume, and a reduced ejection fraction rate, all of which result in the consumption of more oxygen in order to expel a smaller stroke volume of blood. At a critical moment, which depends on both the systemic vascular resistance and the level of myocardial oxygenation, acute left ventricular failure supervenes. The essential pharmacodynamic effect required is an immediate reduction in systemic vascular resistance in order to decrease the work load on the failing ventricle and improve cardiac output.

Systemic vasodilatation[26-28] is the desired aim, and the mechanisms have been reviewed by Cohn.[29-30] Vasodilators, by relaxing

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TABLE I

The Hypertensive Crises: Therapeutic Agents

Situation	Drugs of Choice	Cautionary Drugs	Drugs to Avoid
Hypertensive Encephalopathy	Diazoxide Trimethaphan Sodium nitroprusside	Reserpine Methyldopa	Hydralazine
Accelerated Hypertension with Intracranial Hemorrhage	Diazoxide Trimethaphan Sodium nitroprusside Pentolinium	Reserpine Methyldopa	Hydralazine
Severe Hypertension with Acute and Chronic Renal Disease	Diazoxide Methyldopa Hydralazine Minoxidil Furosemide		
Severe Hypertension in Pregnancy	Diazoxide Hydralazine Methyldopa Reserpine	Trimethaphan Sodium nitroprusside	
Accelerated Hypertension with Acute Left Ventricular Failure	Diazoxide Pentolinium Trimethaphan Furosemide	Hydralazine	
Dissecting Aneurysm of the Aorta	Trimethaphan Reserpine Methyldopa Propranolol		Hydralazine
Pheochromocytoma	Phentolamine Phenoxybenzamine		Methyldopa
Hypertension with Hypovolemia	Volume expansion		Antihypertensives

vascular smooth muscle, increase the compliance of the larger arteries, decrease arteriolar resistance and may dilate venous capacitance vessels.[32] These effects contribute to an improved tissue perfusion.[32] The decrease in left ventricular volume at the end of diastole coupled with the reduction of left ventricular diastolic pressure not only reduces myocardial oxygen needs but improves endocardial perfusion.[32] The reflex tachycardia of vasodilator therapy may become a problem by shortening the diastolic interval and hence decreasing coronary filling time. In the presence of coronary artery disease, a decreased coronary blood flow can easily precipitate frank left ventricular failure.

Since a simultaneous reduction in systemic and left atrial pressure is mandatory in this condition, therapy with ganglion blockers may be indicated but requires close medical supervision. Also, measures to decrease cardiopulmonary blood volume with rotating tourniquets, phlebotomy, and 'loop diuretics' form part of the therapeutic regime (Table I.)

Although the beneficial effect of furosemide in relieving the pulmonary congestion of acute left ventricular failure is attributed to its early and potent diuretic effect, clinical relief is related temporally to a prompt fall in left ventricular filling pressure and usually precedes the onset of the profound diuresis which occurs within fifteen minutes.[33] The immediate increase in venous capacitance followed by the potent diuresis serves in initiating and sustaining a decreased left ventricular filling pressure and a concomitant decrease in myocardial oxygen consumption.

Treatment—In this condition we advise a combination of parenteral diazoxide and furosemide (Tables I and II). Diazoxide should be given at a dose of 5 mg/kg as a rapid intravenous injection. It has a dramatic hypotensive effect that lasts from three to eight hours. It has to be kept in mind that a slow injection is without effect on the blood pressure. Furosemide, when used intravenously in a dose of 40-80 mg is effective in providing clinical relief of pulmonary congestion and peripheral edema. This dose of the furosemide may be repeated in one hour if diuresis is not adequate.

A ganglionic blocking agent such as trimethaphan camsylate (Arfonad® Roche Laboratories) may be quite dramatic in its effect on the patient with left ventricular failure and severe pulmonary edema. It must be given as an intravenous infusion. The initial dose is usually about 1,000 mg given over a ten to fifteen minute period, and the infusion rate is then adjusted so as to obtain the desired therapeutic response. The onset of action of this drug is immediate, but the response is also relatively short unless the continuous intravenous infusion is maintained.

When a longer acting ganglionic

TABLE II

The Hypertensive Crises: Therapeutic Agents/Dosage, Administration and Time-Course Relationship

Drug	Dose and Method of Administration	Onset	Maximum Effect	Duration of Action
Trimethaphan	500mg/ml in IV infusion, titrate	Instantaneous		Transient
Pentolinium	1-25mg IM 10mg/20ml intermittent IV 50-200mg/L IV infusion	30 min 3-10 min 3-10 min	45-60 min 15 min 15 min	3-4 hrs 3-4 hrs 3-4 hrs
Sodium Nitroprusside	50-100mg/L IV infusion, titrate	Instantaneous		Transient
Diazoxide	300-600mg/as rapid IV push	Instantaneous		3-8 hrs
Hydralazine	10-60 mg IM 20-40mg/20ml intermittent IV 50-100mg/L in IV infusion	30 min 10 min 10 min	60 min 30 min 30 min	12 hrs 6-8 hrs
Methyldopa	250-500mg/100ml IV infusion	3 hrs	4-5 hrs	12 hrs
Reserpine	2.5-10mg IM	3 hrs	6 hrs	12 hrs
Phentolamine*	5-30mg IV	Instantaneous		Transient

* Specific for pheochromocytoma.
Use these drugs under continuous blood pressure monitoring. Vasopressors must be immediately available

blocking agent is desired, pentolinium (Ansolysen® Wyeth Laboratories) may be given either intramuscularly or intravenously (Table II). However, the drug has a slower onset of action and is more likely to produce intestinal ileus if continued for an extended period of time.

Hypertensive Encephalopathy

This gradually developing neurologic derangement complicates the course of severe hypertension. The patient presents with occipital headaches, nausea, and vomiting and proceeds through a state of mental confusion before entering coma. There may be bizarre neurologic signs of a focal transitory nature like seizures, monoplegias, aphasia, or cortical blindness. The intracranial pressure, which is usually normal in uncomplicated hypertension is markedly elevated in hypertensive encephalopathy. Changes in capillary permeability secondary to the high arterial pressure result in cerebral edema with flattening of the convolutions, a decrease in the size of the ventricles, and multiple small petechial hemorrhages. The underlying disturbance is a marked increase in cerebral vascular resistance typified by intense arteriolar spasm proceeding sometimes to a necrotising arteriolitis with a drastically reduced blood flow. Most patients demonstrate severe retinal arteriolar spasm accompanied by cotton-wool exudates, flame shaped hemorrhages, and usually papilledema. The papilledema reflects the increased intracranial pressure, and together with the presence of a severely elevated systemic blood pressure is universally accepted as the sine qua non of hypertensive encephalopathy.

Contemporary data are consistent with Byrom's experimental observations that hypertensive encephalopathy is the direct result of vascular abnormalities including spasm, leakage through areas of fibrinoid necrosis in the arterioles, and damaged capillaries with local or generalised edema.[34] Paradoxically hypertension per se is not responsible for the encephalopathy. A similar syndrome can be produced by a decrease in cerebral blood flow. Hypertension, by eliciting cerebral vasoconstriction (myogenic autoregulation), reduces cerebral blood flow. Johansson, Strandgaard and Lassen[35] have stated that a 'breakthrough of cerebral autoregulation with forced vasodilatation, flow increase, and blood-brain damage' characterizes the pathophysiology of the encephalopathic state. According to them, the areas of excessive permeability are responsible for the focal neurologic signs and not the more proximal 'ischemic' areas lying adjacent to the spastic vessels. In fact the authors state that therapy based on reversing cerebral vasoconstriction results in further damage by way of transmission of the arterial pressure to areas of increased permeability. Prompt reduction of the blood pressure alters these autoregulatory phenomena and restores cerebral blood flow to normal.

Treatment—The drugs of choice are diazoxide, trimethaphan, or sodium nitroprusside. We advise that diazoxide may be given in a dose of 5mg/kg as a rapid intravenous injection. Hydralazine, which is a vasodilator of modest antihypertensive potency is best avoided. Caution should be employed with reserpine and methyldopa, for not only is their action delayed, but that drug induced drowsiness may interfere with serial neurologic evaluation. However, with some experience in using these agents, they are quite effective in reversing the encephalopathic changes. The initial dose of reserpine is 2.5 mg and the dose is increased by 2.5 mg every three to four hours until the blood pressure has been reduced to the desired level. No more than a total of 20 mg of reserpine should be given during a twenty-four hour period. Ten mg per day should not be exceeded after the first three days of parenteral drug administration. The drug should not be con-

tinued beyond five days even at the 10 mg dose.

Severe Hypertension with Renal Insufficiency

Although renal insufficiency complicating severe hypertension has been considered in therapy, Moyer and associates[16] showed that effective reduction of blood pressure arrests the deterioration of renal function in patients with severe hypertension. Wood and Blythe[23] demonstrated that glomerular filtration could be increased or at least maintained by treatment in patients with malignant hypertension complicated by renal insufficiency. Mroczek and associates[24] showed that aggressive therapy in azotemic patients in the accelerated phase of hypertension resulted in mild deterioration of renal function initially. However with the maintenance of a reduced blood pressure, there was an improvement in renal function exceeding initial values. Harrington, Kincaid-Smith and McMichael showed that after sustained control of blood pressure, the main pathologic changes in the kidney were a conversion of cellular intimal hyperplasia in the interlobular arteries to fibrous intimal thickening and a conversion of fibrinoid necrosis to hyaline and fibrous tissue. McCormack and co-workers[21] found that in malignant hypertension with renal involvement, the acute arteriolar lesions healed after sustained control of blood pressure.

Recently attention has been drawn to the syndrome of oliguric acute renal failure in malignant hypertension by Mattern, Sommers, and Kassirer[6] and others.[4,5] The authors state that malignant nephrosclerosis occurs frequently enough to justify consideration in the differential diagnosis of oliguric renal failure and severe hypertension.[6] Eknoyan and Siegel[5] have reported that effective therapy in a patient with malignant hypertension and anuria produced a diuresis and return of adequate renal function so that dialysis was not required for over two years. The accelerated phase of essential hypertension with uremia is not always irreversible, aggressive therapy is indicated and should be continued even though dialysis support may be required.[36]

Treatment—Emergency therapy in acute or chronic renal disease consists of diuretics (or ultrafiltration dialysis, depending on the level of renal function) and diazoxide. In addition to diazoxide, which may be given in the usual manner, furosemide must be given in a dose commensurate with the prevailing glomerular filtration rate. A rule of thumb in relation to the dose of intravenous furosemide would be to start with 80 mg and, if ineffective, to double the dose to a maximum of 320 mg. Higher doses may be given if a diuresis does not result, but there is little to gain. As far as intermediate and long-term therapy is concerned, use may be made of methyldopa, hydralazine, or combined vasodilatation (hydralazine or minoxidil) and beta-blockade (propranolol).[37] Although the role of renin as a causative factor in the genesis and progression of malignant hypertension remains speculative at this time, beta-blockade antagonizes the reflex cardioacceleration and renin release secondary to systemic vasodilatation.

Severe Hypertension in Pregnancy

Severe hypertension in pregnancy may be due to the accelerated phase of essential hypertension, the hypertensions of renal vascular[38] or renal parenchymal disease,[39] the preeclampsia-eclampsia syndrome, or miscellaneous states associated with hypertension.[40,42] Preeclampsia is predominantly a disorder of the primigravida and usually occurs after the twentieth week of gestation except in the presence of trophoblastic disease, when it may occur earlier. It is characterized by the development of hypertension with proteinuria and edema. Eclampsia is the occurrence of convulsions in the setting of preeclampsia not attributable to a prior seizure disorder or cerebrovascular accident. Essential and renal hypertensions are detected during the first trimester of pregnancy, and this time course offers a very useful clue in the differential diagnosis of severe hypertension in pregnancy. In addition, the presence of ad-

TABLE III

The Hypertensive Crises: Therapeutic Agents/Mechanisms of Action and Pharmacodynamics

Drug	Mechanism of Action	Cardiac Output	Peripheral Resistance	Heart Rate	Mean Arterial Pressure
Trimethaphan	Ganglion blockade	⇩	⇩	⇧	⇩
Pentolinium	Ganglion blockade	⇩	⇩	⇧	⇩
Sodium nitroprusside	Ganglion blockade Peripheral vasodilatation	⇧	⇩	⇧	⇩
Diazoxide	Peripheral vasodilatation	⇧	⇩	⇧	⇩
Hydralazine	Peripheral vasodilatation				
Methyldopa	False transmitter at adrenergic terminals Central action	N	⇩	⇩	⇩
Reserpine	Catecholamine depletion at adrenergic terminals Central action	N	⇩	⇩	⇩

TABLE IV

The Hypertensive Crises: Therapy-Side Effects and Cautionary Notes

Drug	Side Effects	Cautionary notes
Sodium nitroprusside		Unstable in solution, must be prepared fresh Risk of thiocyanate toxicity
Diazoxide	Transient hyperglycemia Sodium and water retention Reflex cardioacceleration Abrupt cessation of labour	Monitor therapy in heart failure coronary disease aortic dissection Oxytocics reverse cessation of labor
Pentolinium	Postural hypotension Paralytic ileus Urinary retention	Avoid in postoperative state
Trimethaphan		Transient action
Hydralazine	Reflex cardioacceleration	Avoid in aortic dissection intracranial hemorrhage coronary disease
Methyldopa	Sedation	May make serial neurologic evaluation difficult
Reserpine	Sedation Extrapyramidal rigidity	May make serial neurologic evaluation difficult Causes bradycardia, note when using digitalis

vanced retinopathy with sclerotic changes and electrocardiographic evidence of left ventricular hypertrophy, suggest the existence of a chronic hypertension rather than a de novo phenomenon.

The immediate aim in treating the hypertensive gravida is to prevent perinatal and maternal morbidity. Experience in the therapy of severe hypertension consists almost exclusively in the use of parenteral hydralazine. Effectiveness of reserpine alone or in combination with other antihypertensives is disputed.[43, 44] Methyldopa has been used in some centers with excellent results.[45, 46] Recent reports speak favorably on the promptitude and efficacy of diazoxide in pregnancy,[43] but it should be kept in mind that it may produce a temporary cessation of labour by inhibiting uterine contractions.[49] Ganglion blockers are contraindicated since they may produce meconium ileus in the fetus.[49] The pathophysiology and management of hypertension in pregnancy has been the subject of two excellent reviews in a recent symposium.[43,50]

Treatment—Choice of therapy depends upon the clinical condition of the patient. When an immediate reduction in pressure is mandatory, use may be made of diazoxide. Diazoxide should be administered in the standard dosage of 5 mg/kg as a rapid intravenous injection (Table IV). If the patient can tolerate a delay of two to three hours, recourse may be had to reserpine, methyldopa, or hydralazine. Hydralazine alone or in combination with reserpine is the preferred drug regimen. Reserpine is given as an intramuscular dose of 2.5 mg and begins to act within two hours, reaches its maximum effect at three to four hours, and persists for about eight hours. Hydralazine should be given in a dose of 25 mg intravenously or intramuscularly followed by the continuous intravenous infusion of 50 mg in 500 cc of 5 percent glucose administered as rapidly as necessary to control the blood pressure at the desired level.

Acute Dissecting Aneurysm of the Aorta

Prior to 1965 corrective surgery was the only mode of therapy available for dissecting aneurysm of the aorta.[51] Analysis of the hemodynamic variables operating in this entity demonstrated that other than the control of the mean arterial pressure, pulsatile flow emerged as an important consideration.[52] Control of blood pressure was not different between patients who died and those that survived in the series of McFarland and associates[53] and was consistent with the observations of Prokop and co-workers.[52] Pulsatile flow was more important than the level of the mean arterial pressure in the initiation and propagation of a dissecting aneurysm. Emphasis was placed on the idea that both the blood pressure and the pulse pressure be reduced simultaneously. Since the introduction of antihypertensive therapy as an acceptable alternative to surgery by Wheat and Palmer[51] many reports have appeared testifying as to its efficacy.[53, 54] Trimethaphan, reserpine, and methyldopa—while decreasing the systemic arterial pressure—lessen the systolic impulse to the dissecting hematoma. Recently propranolol has been investigated as a form of therapy in this entity, the rationale being its negative inotropic and chronotropic action on the heart. Since vasodilators increase the cardiac output (mainly through a reflex tachycardia) and widen the pulse pressure, they should not be used in this situation.

Treatment—In this condition we would advise that therapy be

'The patient who has experienced a hypertensive crisis continues to be a high risk patient even after the blood pressure has been brought down to acceptable levels . . . Speaking philosophically, the treatment of the hypertensive emergency does not end in the emergency room . . .'

started with trimethaphan (intravenously) together with a diuretic. Methyldopa may be effective. The heart rate (resting recumbent and upright position) and the pulse is a clinical index worth following. A resting heart rate over seventy-two beats per minute, with an overshoot of above twenty beats per minute usually signify that drug therapy is inadequate. If tolerance to methyldopa and trimethaphan exist, vasodilator therapy may be started cautiously after adequate beta-blockade has been instituted with, for instance, propranolol in an oral dose of 40mg q.i.d. As we have mentioned before, a close monitor of the heart rate is mandatory in this situation, a tachycardia implying insufficient beta-blockade to antagonize the reflex cardioacceleration induced by the vasodilator.

Paroxysmal Hypertension with Hypovolemia

In Cohn's syndrome,[55] a relatively common but rarely recognized entity, the patient presents with dehydration, a shocky appearance, in sinus tachycardia, and with severe hypertension. Characteristically, the pulse pressure is narrow and hemodynamically the blood volume is markedly decreased (reflected by the high hematocrit), the cardiac output is decreased, and the systemic vascular resistance is extremely high. These alterations are due to an inappropriate sympathetic response to a primary insult to cardiovascular homeostasis (usually a reduction in blood volume). Unfortunately, this sympathetic overactivity decreases blood volume even further, forming a vicious cycle. Not infrequently is hypovolemia a cause of intradialysis hypertension, and it is vital to recognise the pathophysiology of this state since rational therapy should consist of replenishing blood volume and not resorting to the traditional ultrafiltration technic. If adrenergic blockers are used, by inhibiting neurogenic vasoconstriction and venoconstriction, they destroy the body's last defense against extreme hypovolemic shock.

Hypertension Associated with Pheochromocytoma

The hypertension associated with pheochromocytoma is typically paroxysmal in a little more than 50 percent of patients and is sustained in the rest. Diagnosis in the latter category is difficult, but the signs and symptoms of hypermetabolism characterized by weight loss, diaphoresis, tremulousness, and fever may be helpful. Moreover, the occurrence of a paroxysmal hypertensive episode in a patient with a previously sustained hypertension should bring to mind an underlying pheochromocytoma. The pathophysiology diagnosis and treatment of pheochromocytoma has been the subject of two exhaustive reviews in a recent symposium.[56,57]

Alpha-adrenergic blockers have been used primarily to counteract the hypertensive effects of catecholamines released during a crisis. Phentolamine (Regitine® Ciba Pharmaceutical Co.) is available for intravenous use, but oral phenoxybenzamine (Dibenzyline® Smith, Kline & French Laboratories) is the preferred agent for preoperative preparation and chronic therapy. It is well to be aware that severe hypotension may follow therapy with alpha-adrenergic blockers in patients whose tumors secrete significant amounts of epinephrine. This is due to the unapposed beta-adrenergic vasodilating effects of epinephrine. Tachyarrhythmias associated with a hypertensive episode have been handled successfully with beta-adrenergic blockers. Since the myocardium of these patients is sensitive to beta-blockade, small doses should be used. Moreover, in the patient with focal myocarditis (catecholamine cardiomyopathy), congestive cardiac failure has resulted from the negative inotropic effect of beta-blockade. Methyldopa therapy has been reported to precipitate hypertensive crises in patients with pheochromocytoma and is best avoided in this situation.

Treatment—In a crisis we would advise the intravenous use of phentolamine starting with a dose of 5-10 mg. Although the effect is instantaneous, the effect is transient. In addition to repeating the dose, the patient may be started on phenoxybenzamine in a single oral daily dose, the strength of the agent being titrated from 10 mg a day upwards.

Phenoxybenzamine (Dibenzyline®) is likewise an excellent adrenergic blocking agent when given orally. The initial dose is 10 mg given each morning with the dose increased every other day by 10 mg until adequate blockade has been obtained. This dose arrived at by titration is then given daily.

Summary

The spectrum of the hypertensive crises together with the recommended drugs are summarized in Table I. The therapeutic use of these agents is summarized in Table II. An idea of the altered systemic hemodynamics is mandatory

since although all the drugs listed are able to reduce the blood pressure, hydralazine may intensify aortic dissection and do harm to the patient with an intracranial hemorrhage. It still remains the drug of choice in the hypertensive gravida and in the patient with modest renal failure.

Conclusion

In conclusion, we emphasize the fact that the patient who has experienced a hypertensive crisis continues to be a high risk patient even after the blood pressure has been brought down to acceptable levels. The necrotising arteriolitis will never heal, and organ function will never return to normal unless the patient is kept under constant superivison and blood pressure regulation. Speaking philosophically, the treatment of the hypertensive emergency does not end in the emergency room. We advise that oral antihypertensive therapy be started immediately with the emergency drug therapy and that the dose be adjusted over a period of days in order to ensure effective long-term control. □

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Recognizing renovascular hypertension

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IN A survey conducted by the United States Public Health Service in 1960-1962, it was estimated that there were at least seventeen million adults in the United States with definite hypertension.[1] Another sixteen million, two hundred thousand adults were estimated to have borderline hypertension. Current estimates suggest there are over twenty-three million adults in the United States with definite hypertension and as many as half of these remain undiagnosed.[2]

Since the majority of patients with high blood pressure have primary or essential hypertension, it is difficult for the physician to recognize those patients who have secondary or curable hypertension. Hypertension associated with pheochromocytoma, primary aldosteronism, Cushing's syndrome, coarctation of the aorta, and renal artery disease are all potentially curable. Renovascular hypertension is the most frequently encountered form of surgically correctable hypertension and is estimated to exist in 5 to 15 percent of the hypertensive population.[3] It is of great importance for all physicians to be sufficiently informed about this clinical entity if a maximum number of curable hypertensive patients are to be suspected, diagnosed, and treated.

Historical Background

In 1934 Goldblatt published his now famous series of experiments in which he was able to induce hypertension in dogs by constriction of the renal artery.[4] This classic physiologic experiment laid the groundwork for the subsequent recognition of renal artery disease as a clinical cause of hypertension. In 1944 Sensenbach reported on the treatment of hypertension by means of nephrectomy of the unilateral small kidney, and in 1954 Freeman et al reported on the successful treatment of hypertension secondary to renal artery stenosis by direct vascular reconstruction.[5,6] Subsequently, many hypertensive patients who were found to have a small kidney by intravenous pyelography underwent unilateral nephrectomy. Initial enthusiasm for this procedure was quickly tempered by mediocre results. In 1956 Smith reported that only 26 percent of hypertensive patients became normotensive after having a

Figure 1. Arteriosclerosis producing a stenosis of the proximal right renal artery.

Figure 2. Fibromuscular dysplasia of the left renal artery showing typical "string of beads" appearance.

TABLE I

Clinical Characteristics of Essential Hypertension and Renovascular Hypertension Cured by Surgery *

	Essential Hypertension,%	Renovascular Hypertension,%
Duration of hypertension		
< 1 year	12	24
> 10 years	15	6
Age of onset (> 50 yr.)	9	15
Family history of hypertension	71	46
Fundi (grade 3 or 4)	7	15
Bruit		
Abdomen	9	46
Flank	1	12
Abdomen or flank	9	48
BUN (> 20 mg/100 ml)	8	15
Serum K (< 3.4 mEq)	8	16
Serum CO_2 (> 30 mEq)	5	17
Urinary casts	9	20
Proteinuria (trace or more)	32	46
Number of patients	339	175

*N. Simon, S.S. Franklin, K.H. Bleifer, and M.H. Maxwell. JAMA 220:1209, May 29, 1972.

nephrectomy for a unilateral small kidney.[7] With the availability of renal arteriography, renal artery lesions could be readily detected. In patients with hypertension and demonstrable renal artery stenosis, reconstruction of the renal artery or nephrectomy still relieved hypertension in only about 50 percent. This can be explained in large part by the fact that in normotensive persons over the age of fifty, approximately one half of them will have incidental renal artery stenosis noted on arteriography.[8] More discriminating diagnostic tests now available include renal scanning, divided kidney function tests, assay of renal vein plasma for pressor substances, and percutaneous renal biopsy.

Pathophysiology

Renovascular hypertension may be caused by arteriosclerosis, fibromuscular dysplasia, renal artery aneurysm, renal artery embolus or thrombosis, dissecting hematomas of the renal artery, or trauma.

Arteriosclerosis is responsible for stenotic lesions in the renal artery in 60 to 70 percent of patients. In most instances the atherosclerotic plaque and stenosis occurs in the proximal third of the renal artery, especially in the area surrounding the orifice of the renal artery, as seen in Figure 1. Atherosclerotic stenosis is more frequently noted in the older age range of those patients with renovascular hypertension.

Fibromuscular dysplasia is the cause of renal artery stenosis in 20 to 25 percent of patients (Figure 2). It tends to occur in a younger age group, usually under the age of forty-five. Fibromuscular dysplasia is more frequent in females and is bilateral in 40 percent of reported cases. The pathologic changes involve all three layers of the artery and can consist of either intimal fibroplasia, medial fibroplasia, or subadventicial fibroplasia. A fourth type consists of diffuse fibromuscular hyperplasia of the entire vessel wall.

The mechanism whereby renal artery stenosis produces hypertension is based upon the renin-angiotensin-aldosterone system. Renin is an enzyme produced in the juxtaglomerular apparatus in the kidney. Renin by itself does not cause vasoconstriction. However, renin released into the circulation acts upon an alpha-2-globulin elaborated by the liver, angiotensinogen, to produce angiotensin I which is converted to angiotensin II. This latter compound is an extremely potent vasoconstrictor and also stimulates the release of aldosterone from the adrenal cortex. Angiotensin II directly decreases renin secretion creating a feedback control mechanism.

Diagnosis

The diagnosis of renovascular hypertension can be suspected from the history and physical examination, and it is confirmed by laboratory and x-ray evaluation. In a cooperative study of renovascular hypertension the clinical profiles of a series of 175 patients were examined in an attempt to determine which, if any, characteristics would separate them from patients with essential hypertension.[9] The results are listed in Table I. Other factors suggestive of renovascular hypertension are the absence of a family history of high blood pressure, the onset of hypertension under age twenty or over age fifty, a history of renal trauma or previous arterial emboli, or a sudden exacerbation of existing hypertension. Physical findings that may lead one to suspect the diagnosis of renovascular hypertension are an abdominal or flank bruit in combination with hypertensive retinopathy.

The rapid sequence excretory urogram continues to be the most valuable initial screening test for renovascular hypertension. When multiple films are made within the first five munutes after injection of an appropriate contrast material, the urogram will be abnormal in 80 percent of patients with renovascular hypertension.[10] The radiologic criteria used to support the diagnosis are: a difference in size of the two kidneys of 1.5 cm or greater, the delayed appearance of contrast material in a contracted pelvis on the involved side, ureteral notching produced by collateral vessel hypertrophy, defects in the renal silhouette suggesting previous infarction, and delayed hyperfunction on the involved side. Thus, the intravenous urogram is able to demonstrate indirect evidence of a renal artery lesion as well as to serve as a differential renal function test.

Another test that has proven to be

of value is the radioisotope renogram. In this study radioactively labeled orthoiodohyppurate is injected intravenously and the radioactivity over each kidney is measured. A graphic display of the appearance and disappearance of the radioactivity in an involved kidney will show a slow appearance of the radioactivity because of decreased renal blood flow and a prolonged excretory phase again reflecting decreased perfusion of the involved kidney.[11] In order to further define the role of a stenotic lesion in contributing to a patient's hypertension, the development of the renin bio-assay and immunoassay has been very valuable. By means of retrograde venous catheterization via the femoral vein, one is able to obtain blood samples from both renal veins and also from the inferior vena cava. Successful surgical results can be predicted in 80 to 90 percent of cases if one finds an elevation in the involved kidney's renal vein renin level of at least 1.5 times greater than the contralateral kidney.[12] This study is now routinely done in conjunction with renal arteriography.

The differential renal function test as performed by Howard has been largely abandoned because of the high complication rate following ureteral catheterization. Bilateral renal biopsy has been of some value in demonstrating tubular atrophy and increased juxtaglomerular cell granularity on the involved side.

Treatment

Some patients with renovascular hypertension can be treated with antihypertensive medications. Although blood pressure is reduced, the involved kidney may continue to atrophy with deterioration of renal function over the course of several years. Medical therapy may be recommended for those patients with very mild hypertension that is easily controlled, those who have stable renal function, and those patients with other serious illnesses or advanced age.

The surgical treatment of renovascular hypertension has been greatly enhanced since the field of arterial reconstructive surgery has developed. Renal artery reconstruction is the preferred method of treatment. This can be accomplished utilizing several methods. The most frequently used technique is an autogenous saphenous vein bypass graft from the aorta to the renal artery. Other techniques used include endarterectomy with or without a vein patch graft, reimplantation of the renal artery, and excision of a diseased segment of renal artery with end to end anastomosis of the renal artery. The internal iliac artery is an ideal autogenous graft and this has been particularly recommended for use in children.[13]

In the patient with a unilateral lesion and confirming differential function tests, one can expect up to a 90 percent likelihood of relieving hypertension following appropriate surgical treatment.[14] The highest success rates are reported in young patients with unilateral fibromuscular dysplasia. Patients who have renovascular hypertension on the basis of arteriosclerosis have an 87 percent chance for improvement or cure of their hypertension if the atherosclerotic lesion is localized to the renal artery. However, if diffuse arteriosclerosis is present, as evidenced by a history of myocardial infarction, angina, congestive heart failure, cerebral vascular accident, or peripheral vascular disease, the likelihood of successful renal arterial reconstruction relieving hypertension is only 53 percent.[15]

The operative mortality for renal arterial reconstruction has been reported to be between 2 and 4 percent.[14,15] Lower rates are noted in series which include a large number of patients with fibromuscular dysplasia who are generally in a younger age group.

Nephrectomy continues to be a useful procedure for certain indications such as (1) unilateral severe renal dysfunction with minimal chance for improvement, (2) elderly or debilitated patients in whom surgery must be expeditious, (3) distal arterial lesions beyond the scope of present day techniques for repair, and (4) failure of previous attempts at direct arterial reconstruction or bypass.

If indeed 10 percent of all hypertensives are suffering from renovascular hypertension, we can assume that there are at least two million, three hundred thousand adults in the United States who have a curable form of high blood pressure. □

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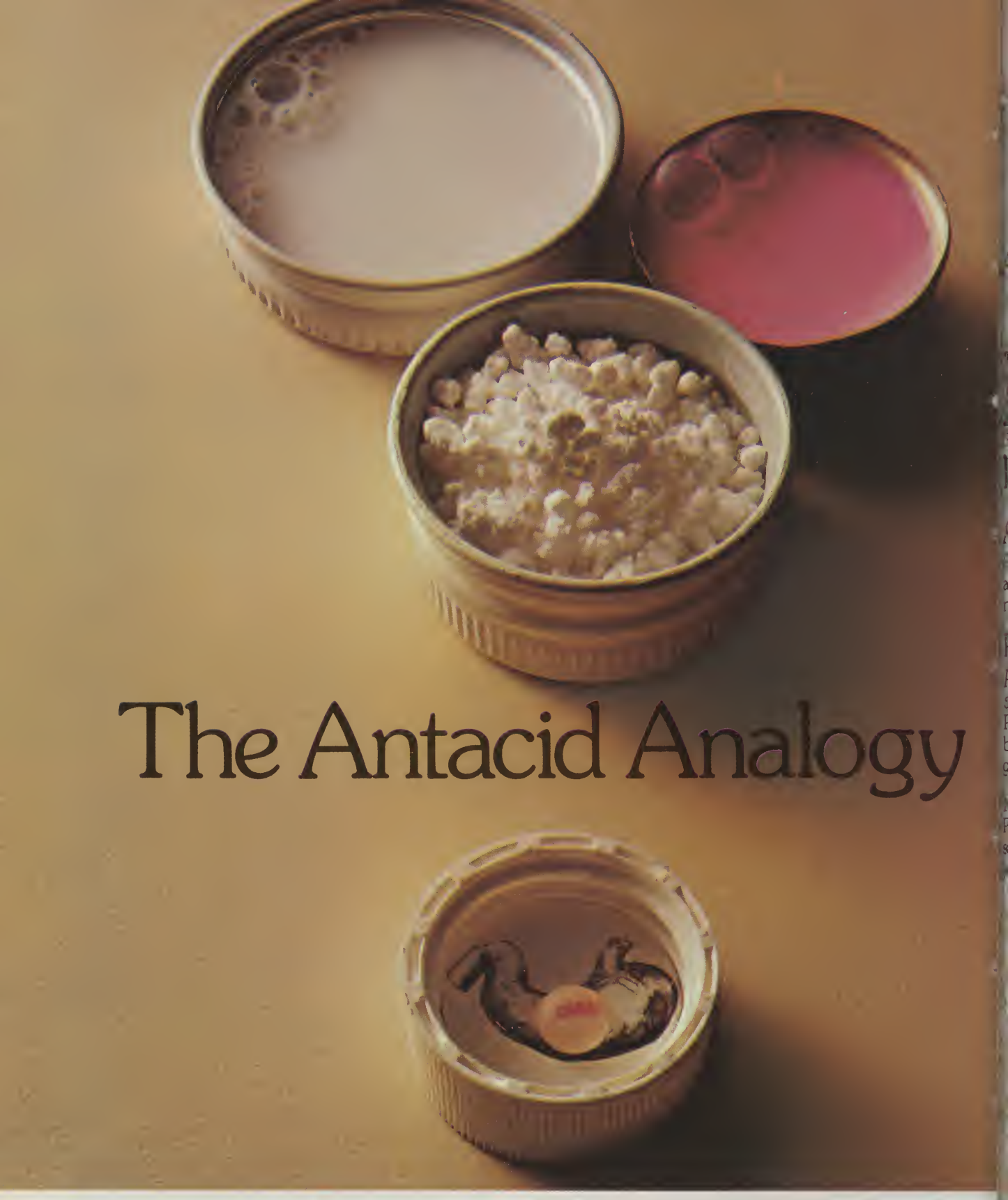

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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HYPERTENSION may present in one of two main clinical forms: a slowly progressive or "benign" form which follows a more chronic pattern and an accelerated or malignant form which, if untreated, has a rather short course.

In the malignant phase of this disease, without treatment, a dire prognosis can almost certainly be predicted within five years. Keith, Wagener, and Barker[1] showed that the one-year survival rate of untreated patients with malignant hypertension is about 20 percent and that within five years nearly all patients succumb (only 3 percent survive). With the introduction of potent antihypertensive drugs, Harington, Kincaid-Smith and McMichael,[2] in a series of eighty-two patients with malignant hypertension treated from 1951-1957, showed that the survival rate increased to 50 percent at one year, 33 percent at two years, and 25 percent at four years as compared with a 10 percent survival in the first year in their untreated cases.

In the last fifteen years, with the introduction of still more potent antihypertensive drugs, one might expect even better survival rates. During the course of a prognostic evaluation of cases treated in the division of hypertension at the Henry Ford Hospital, this was found to be true. This study summarizes the clinical and laboratory findings on sixty-seven treated patients with malignant hypertension between the years of 1952 and 1961 and reports on their follow-up to the end of 1966.

Patients and Methods

Seventy-five patients with malignant hypertension were treated in the division of hypertension of Henry Ford Hospital from 1952 to 1961. All patients had papilledema, plus retinal exudates or hemorrhages, and fixed diastolic hypertension. The pretreatment casual diastolic blood pressure was 140 mm Hg and above, whereas the basal (resting, reclining) and hospital (third to fourth day, sitting) diastolic pressures were greater than 120 mm Hg. All were private patients and were followed personally by us. Forty-one patients were men and thirty-four women. Their average age was forty-seven years. Of the seventy-five, we lost contact with eight, of whom six were first seen prior to 1958 and two in 1958 and thereafter. Thus only sixty-seven cases were actually followed up to five years and beyond. The patients were referred to us either through the emergency room of Henry Ford Hospital or directly by practicing physicians.

All patients were hospitalized, and systematic treatment was initiated during hospitalization. After discharge they were followed in the outpatient hypertension clinic of Henry Ford Hospital at intervals of one week to three months. All drugs were given separately (i.e. no combination tablets), and the dosage and frequency of clinic visits was individualized according to response.

In order to compare the long-term survival from the date of diagnosis to five years and beyond, between the pre- and post-thiazide and guanethidine era, the patients were separated into two groups: one from 1952 to 1957, consisting of forty-two patients, and the other from 1958 to 1961, composed of twenty-five patients. The 1952-1957 group was treated with ganglionic blockers, reserpine and/or hydralazine, whereas in the 1958-1961 group the treatment consisted principally of guanethidine with either thiazides or chlorthalidone. One patient seen in December 1957 was started on chlorothiazide and thus was included in the 1958-1961 group. A patient in the 1952-1957 group was initially treated with ganglionic blockers, reserpine and hydralazine (1955), but later thiazides (1958) and guanethidine (1959) were added. Finally she developed uremia and received renal homotransplant (1965). Therefore, this case could be listed in either group.

The effect of therapy on blood pressure levels was estimated by comparing pre- and post-treatment casual, hospital, and/or basal blood pressures. While in the hospital, all patients were carefully instructed in the technique of determining their own blood pressure with an Autosfig® (Propper Co.) Upon discharge, they were directed to record home blood pressures twice a day and were given specific written directions on how to properly regulate antihypertensive drug dosage (ganglionic blocker or guanethidine) on the basis of alterations in the level of the standing systolic blood pressure.[3,4] The usual daily dosage of the drugs used in the 1958-1961 group was as follows: guanethidine (Ismelin,® Ciba) 50 mg plus chlorothiazide (Diuril,® Merck Sharp & Dohme) 1000 mg or chlorthalidone (Hygroton,® U.S.V. Pharmaceutical) 100 mg or hydrochlorothiazide (Hydrodiuril,® Merck Sharp & Dohme, Esidrix,® Ciba) 100 mg or bendroflumethiazide (Naturetin,® Squibb) 5 mg. Since 1961 the majority of the patients have been, in addition to guanethidine, or chlorthalidone. In some instances mecamylamine (Inversine,® Merck Sharp & Dohme) 2.5 mg (to counteract diarrhea produced by guanethidine) and hydralazine (Apresoline,® Ciba) 100-200 mg was also given, but the principal drugs in the series were guanethidine plus thiazides or chlorthalidone.

Drug dosage was gradually increased until the average diastolic blood pressure in the standing position was below 90 mm Hg on three successive days, if this could be accomplished without a rise in serum creatinine or undue side effects.

This study shows that in the last fifteen years, with the introduction of more potent anti-hypertensive drugs, survival rates among patients with malignant hypertension have improved.

The home blood pressure recordings were made in both sitting and standing positions. Drugs were labeled and the patient was educated as to their names. For those drugs which produce orthostatic hypotension (ganglionic blockers or guanethidine), instructions were given to the patient to take the drug in the designated dose at 7 a. m. and 7 p. m. (or other more appropriate times). The patients were instructed to bring in a written record of all blood pressure readings and labeled bottles of medicines at each visit, so that appropriate adjustment could be made in drug dosage.

Patients with a serum creatinine of 1.5 mg/100 ml or below and blood urea nitrogen (BUN) of 25 mg/100 ml or below were advised to take the designated dose of the ganglionic blocker or guanethidine only if the standing systolic blood pressures were 120 mm Hg or above (i.e., to omit the dose if standing systolic blood pressure was below 120 mm Hg). In the presence of advanced azotemia (i.e. BUN over 60 mg/100 ml and serum creatinine above 3 mg/100 ml), or when symptoms of angina pectoris or cerebrovascular insufficiency were apparent, guanethidine or ganglionic blockers were omitted if standing systolic blood pressure was below 150 mm Hg or some other level previously determined to be most desirable for that particular patient. When mild to moderate azotemia (BUN 25-60 mg/100 ml and serum creatinine 1.5 - 3 mg/100 ml) was present, the critical level of standing systolic pressure for titration of the dosage of ganglionic blocker or guanethidine was 130-140 mm Hg.

In addition to estimation of years of survival, the effectiveness of treatment in the 1958-1961 group was assessed by taking into consideration various parameters such as retinopathy, blood pressure, left ventricular hypertrophy, proteinuria, and serum creatinine.

Results

Figure 1 shows the percentage of survival, in years, for each of the two groups. There is a substantial increase in the five-year survival of the post-thiazide and guanethidine group (72 percent) as compared to the pre-thiazide group (12 percent). There is only a slight increase in the survival rate of the patients treated during the pre-thiazide and guanethidine years by comparison with the untreated patients of Keith, Wagener, and Barker.[1]

When the blood pressures recorded initially at the hospital by the admitting physician and the casual (office) blood pressures of the groups (taken in the sitting position) were compared, the reduction of the blood pressure was far greater in the 1958-1961 group than in the 1952-1957 group (Table I). In the 1958-1961 group there was a marked reduction of the systolic and diastolic pressures by the end of the hospitalization and/or at the outpatient clinic visit one year after discharge. Likewise, both systolic and diastolic blood pressures were maintained at similar reduced levels by the end of the third and fifth years after initiation of treatment. The average sitting systolic blood pressures were below 180 mm Hg, and the average sitting diastolic pressure was maintained about 100 mm Hg. This degree of blood pressure reduction resulted in over 70 percent five-year survival. By contrast, in the 1952-1957 group, only slight to moderate decrease in systolic and diastolic blood pressure was achieved. The systolic and diastolic blood pressures by the time of discharge and/or at the end of the first and third year were only moderately lower than those taken prior to initiation of treatment. In those patients of this group who survived for five years, there was a marked reduction in the systolic and a moderate decrease in the diastolic pressure at the end of the fifth year (Table I).

The age range and average age and the range of survival in months and average survival in months of all patients in both groups are listed in Tables II and III. Uremia was the principal cause of death (57 percent) in the 1952-1957 group and less prevalent cause of death (29 percent) in the 1958-1961 group.

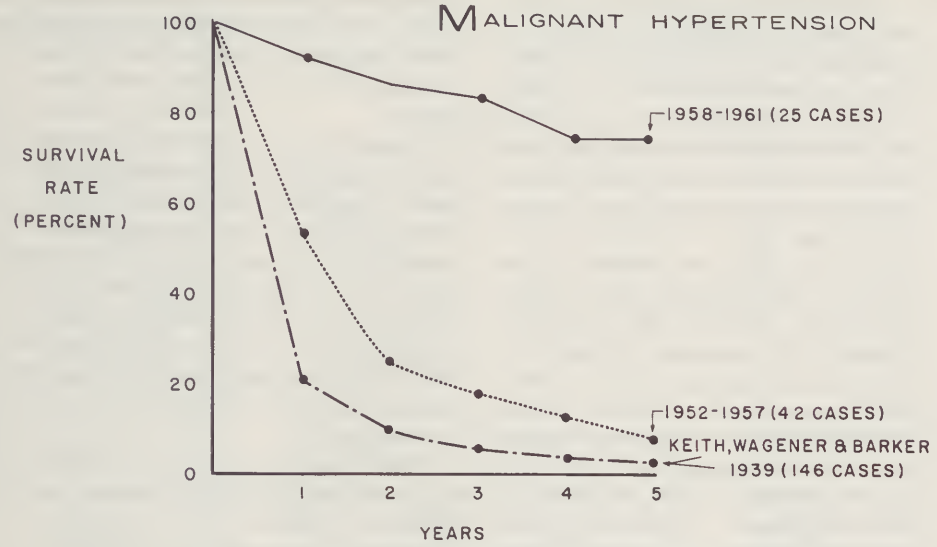

Figure 1—The survival rate of treated patients with malignant hypertension in the pre-(1952-1957) and post-thiazide and guanethidine era (1958-1961) as compared to each other and to the untreated series of Keith, Wagener, and Barker (1939).

TABLE I

Comparison of Admission and Follow-up Blood Pressures between the Two Groups

Blood Pressure Systolic / Diastolic	1952-1957 Group	1958-1961 Group
Admission	240/(28)	253/(19)
Blood pressure	146	147
Blood pressure on discharge or end of 1st year (office)	215/(27)	164/(18)
	128	100
Blood pressure at end of 3rd year (office)	235/(7)	164/(14)
	120	103
Blood pressure at end of 5th year (office)	182/(4)	166/(14)
	120	98

*Numbers in parenthesis represent cases studied

TABLE II

Treated Patients with Malignant Hypertension

1952-1957

Sex	Age Range	Average Age	Range of Survival in Months	Average Survival in Months
Female	27-70	46	1-116	24
Male	23-74	48	1-104	17.5

TABLE III

Treated Patients with Malignant Hypertension

1958 1961

Sex	Age Range	Average Age	Range of Survival in Months	Average Survival in Months
Female	17-61	44	1-104	62
Male	31-71	49	18-108	64

In order to correlate the survival rate with the degree of azotemia, the forty-two patients in the 1952-1957 group were arbitrarily divided into two subgroups: one consisting of patients who survived less than six months, and one of patients who survived six months and longer. When the level of azotemia was correlated with the months of survival, it was evident that survival correlated inversely with the initial degree of azotemia (Table IV). When the subgroup of the 1952-1957 period with survival of six months and beyond was compared with the corresponding subgroup of the 1958-1961 group (Table V), it was apparent that while their average serum creatinine levels were similar, there was an increase of more than two years in survival among the latter group. This suggests that modern antihypertensive drug therapy is responsible for the favorable outcome in the 1958-1961 group.

Tables VI and VII demonstrate that in the presence of mild to moderate elevation of BUN and serum creatinine, for a similar degree of azotemia, survival is significantly higher in the patients treated with thiazide or chlorthalidone and guanethidine than in the patients who received ganglionic blockers and/or rauwolfia derivatives and hydralazine.

Table VIII summarizes the clinical and laboratory changes observed in patients treated for malignant hypertension from 1958 to 1961. Improvement in funduscopic findings were observed in twenty-one of

TABLE IV

Correlation of Survival and Azotemia in Malignant Hypertension Treated in 1952-1957 (42 Cases)

	Less Than 6 Months Survival	Survival of 6 Months or More
Number of Cases	21	21
Months of Survival	2	43
Average BUN mg/100ml	56 (23-110) 5 cases	38 (16-54) 6 cases
Average NPN mg/100ml	104 (55-170) 13 cases	58 (40-96) 7 cases
Average Serum Creatinine mg/100ml	7.7 (2.1-18.2) 6 cases	1.9 (0.8-4.0) 7 cases

TABLE V

Comparison of Serum Creatinine and Survival for More than 6 Months

Group	Serum Creatinine mg/100 ml (range)	Months (range)
1952-1957 (21 cases)	1.9 (0.8-4.0)	42 (7-116)
1958-1961 (23 cases)	1.8 (0.6-5.1)	69 (18-108)

TABLE VI

Correlation of Similar Levels of BUN with Survival

Group	BUN (mg/100 ml) Mean ± S.D. (Range)	Survival (Months)
1952-1957 (9)	47 ± 17 (28-76)	19 ± 14
1958-1961 (11)	38 ± 9 (27-70)	42 ± 23

TABLE VII

Correlation of Similar Levels of Serum Creatinine with Survival

Group	Serum Creatinine mg/100ml Mean ± S.D. (Range)	Survival (Months) Mean ± S.D. (Range)
1952-1957 (6 cases)	2.1 ± 0.6 (1.6-3.0)	14 ± 15 (3-40)
1958-1961 (9 cases)	2.1 ± 0.5 (1.5-3.0)	56 ± 24 (18-82)

twenty-five, while no change occured in the remaining four. Of the twenty-three patients in whom basal, hospital, and home blood pressures were measured, eighteen showed marked reduction in diastolic blood pressure; five had either an increase or no change. All five patients whose blood pressure was not reduced died in less than five years. Ten of twenty-three patients with follow-up electrocardiograms had electrocardiographically demonstrated regression in left ventricular hypertrophy, a result similar to that reported by Harington et al.[2] Of twenty-three patients who had follow-up urinalysis, twelve showed a reduction in proteinuria. The change in serum creatinine was the least favorable (Table VIII).

TABLE VIII
Overall Clinical and Laboratory Changes in Treated Malignant Hypertension (1958-1961 Group)

	Improved	Unchanged	Deteriorated
Fundi	21	4	
Blood Pressure	18	2	3
EKG	10	12	1
Proteinuria	12	6	5
Serum Creatinine	8	5	8

Discussion

This study suggests that the addition of guanethidine plus thiazides or chlorthalidone to our antihypertensive drug armamentarium has favorably influenced the prognosis of treated malignant hypertension. In the past, powerful antihypertensive drugs, such as ganglionic blockers alone or in combination with rauwolfia derivatives or hydralazine, had a rather disappointing effect in retarding the disease and improving survival. Our results in the 1952-1957 group, while somewhat in agreement with those reported by Harington et al.[2] and Mohler and Freis,[5] are not as good as those obtained by others.[6,9]

Perry and Schroeder[6] and Bjork et al.[7] achieved an approximately 50 percent four-year survival, using ganglionic blockers and hydralazine. Smirk,[8] using principally ganglionic blocking agents, observed a four-year survival rate of 56 percent in patients with malignant hypertension. Simpson and Smirk[9] concluded that while effective treatment greatly improves the five-year survival, it is difficult to increase survival above 50 percent.

The five-year survival rate in the group treated by Dustan et al.[10] from 1951 to 1957 was also higher (33 percent) than in our group (12 percent) treated during the same period of time. Comparison between these two groups is not possible, however, since the inclusion of patients in the former group was based on numerical grading and not on the presence of papilledema.

Bjork et al.[7] stated that in their series the survival rate had improved considerably with the addition of chlorothiazide. However, their experience with thiazides was limited to eighteen months and no precise survival figures were given.

The striking difference in survival between the 1952-1957 and 1958-1961 groups in our series can probably be attributed to two factors. The first factor, of course, is the introduction of effective antihypertensive drugs such as thiazides, chlorthalidone, and guanethidine in 1958 and thereafter. Furthermore, these drugs in additon to their effectiveness are devoid of the severe untoward side effects of the ganglionic blockers which were the principal drugs used in the 1952-1957 group. Therefore guanethidine, thiazides, and chlorthalidone were titrated and used to their maximum dosage without serious side effects, and this probably was the reason for improved survival.

One might argue, however, that the improved prognosis in survival in the 1958-1961 group is not necessarily due to the use of more effective and tolerable antihypertensive agents per se, but to the method of treatment: namely, titration of the dosage of guanethidine according to the standing systolic blood pressure. This is certainly a valid argument, and it is quite possible that in addition to the greater effectiveness of the modern drugs, our technique of treatment might have contributed to the increased survival rates as compared to corresponding series of others. It should be emphasized, however, that the same therapeutic principles were applied with the ganglionic blockers in the 1952-1957 group but without much therapeutic success. Nevertheless, we believe that both the effectiveness of the modern antihypertensive drugs and our method of titrating guanethidine according to standing systolic blood pressures have contributed to the improved prognosis in the 1958-1961 group.

In our experience, based on the treatment not only of malignant hypertension but also of other forms of severe hypertension, this therapeutic approach, when it is properly applied to patients receiving ganglionic blockers or guanethidine, is most effective. It is not only successful in normalizing the blood pressure but is also safe in avoiding serious hypotensive episodes and disturbances of cerebral, cardiac, and renal function.

The second factor which might account for the improved prognosis of the 1958-1961 group is that azotemia was less severe and less prevalent (56 percent) as compared to the 1952-1957 group (78 percent). Since an inverse relationship exists between the degree of azotemia and survival (Table IV), the outcome even in the 1958-1961 group was poor when azotemia was severe. However, when the elevation of BUN and serum creatinine was mild to moderate, the prognosis of the patients who received guanethidine plus thiazides or chlorthalidone was far more favorable than that of the

patients who were given ganglionic blockers with or without rauwolfia derivatives and hydralazine (Tables VI and VII). Hence, it appears that the improved survival of patients treated in 1958 and thereafter, as compared to those treated from 1952-1957, is mainly due to change in treatment and not to the pretreatment difference in the degree of azotemia.

Many authors have stressed the ominous outcome if seriously impaired renal function is present at the time of diagnosis and initiation of treatment of malignant hypertension.[2, 5-11] When the initial BUN is below 80 mg/100 ml, renal function may remain stationary or improve slightly with treatment. However, when renal function is severely impaired, progressive deterioration generally occurs.[2] Moyer et al. have shown that patients with malignant hypertension, as compared to patients with so-called "benign" hypertension, tend to have greater renal damage in association with more severe generalized vascular disease.[12] In addition, these authors have shown that with effective treatment, renal deterioration is frequently arrested or delayed, and mortality is reduced.[13] Moreover, pathological observations by Harington et al.[2] confirm that following treatment with antihypertensive drugs, amelioration of the histological picture of the renal vasculature occurs; that is, intimal hyperplasia is converted to fibrous intimal thickening and a "healing" of fibrinoid degeneration to hyaline and fibrous tissue is seen. Similarly, McCormack and associates have shown that patients treated for a long period of time almost always exhibit remission and healing of the acute arteriolar lesions.[14]

Conclusion

In concluding the discussion we would like to state our belief that the increased survival of the 1958-1961 group (treated with sulfonamide saluretics, hydralazine, and guanethidine), as compared to the 1952-1957 group, is not necessarily due to a peculiar effect or effects of the drugs used, but to the fact that in the 1958-1961 group we were able to reduce and maintain the blood pressure, through close follow-up, to normotensive or near normotensive levels with minimum possible side effects.

If alpha methyldopa had been available at the beginning of this study, it is conceivable that we might be able to obtain even better results than those reported herein. Moreover, recent studies suggest that replacement of guanethidine and alpha methyldopa by beta adrenergic blocking agents in combination with vasodilators (i.e. diazoxide, hydralazine) and in conjunction with sulfonamide diuretics might further improve prognosis in severe hypertension.[15]

Summary

The prognosis of sixty-seven patients with malignant hypertension whose treatment began in the division of hypertension of Henry Ford Hospital from 1952 to 1961 was assessed. In order to evaluate the effect of the addition of guanethidine and sulfonamide saluretics in 1958, the cases were separated into two groups: one starting treatment from 1952 to 1957 and the other from 1958 to 1961. In the 1952-1957 group, the five-year survival rate was 12 percent (5 of 42), whereas in the guanethidine plus thiazides or chlorthalidone-treated group (1958-1961), it was 72 percent (18 of 25). There was an inverse relationship between the degree of azotemia and years of survival. In severe azotemia, the prognosis in both groups was grave. In mild azotemia, the survival in the group treated with guanethidine plus thiazides or chlorthalidone was surprisingly good. In the majority of the patients of the 1958-1961 group, a significant reduction in blood pressure (from 253/147 to 166/98) and retinopathy was seen; there was also a regression in proteinuria and left ventricular hypertrophy, whereas the effect on serum creatinine was less favorable. An effective therapeutic approach in the treatment of malignant or severe hypertension by titrating the dosage of guanethidine according to the standing systolic blood pressure has been outlined. □

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Essential hypertension: treatment of ambulatory patients

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HYPERTENSION is an hereditary disease, the characteristic of which appears to be carried in the blood vessel. As the blood pressure becomes elevated, the disease becomes associated with an increasing incidence of atherosclerosis and major vascular pathology. It is the primary anatomical vascular damage that determines the prognosis by its effect on the local vascular bed in critical organs.

Statistics collected by the American Heart Association in 1968 show that hypertension is a major cause of morbidity and mortality in the United States today (Figure 1). These statistics indicate that there are about 8,450,000 patients with uncomplicated disease and more than 12,000,000 patients with hypertensive heart disease. Figure 2 indicates the sharp reduction in the death rate due to hypertension, apparently a result of drug therapy.[1]

Although specific statistics are not readily available to serve as a basis for drawing definitive deductions as to the frequency and adequaćy of the therapy of essential hypertension, it would appear that less than half of those affected are receiving therapy, and less than 20 to 30 percent of those treated are receiving adequate therapy. Table I is a summary of the results of a study by Wilber and Barrow which shows the effect of aggressiveness of treatment of hypertension on the number of patients who come under adequate therapy. A study project team was sent into a geographical area to determine the incidence of hypertension, treated and untreated, and the adequacy of treatment. Only 25 percent of those with hypertension were receiving treatment prior to the study, and of these only 15 percent were under adequate control. The mere presence of the study group, together with detection of unsuspected hypertension and the ready availability of therapy, increased the number of patients under treatment to 50 percent. In the same study, when aggressive management was introduced (home follow-up visits by a nurse were instituted), the incidence of patients coming under treatment was 86 percent, and 80 percent of these were receiving adequate therapy. It was found that after the external influence was withdrawn, less than half of the patients would receive adequate treatment if dependent on the patient's own initiative, and only 55 percent continued with any antihypertensive therapy of any kind. Althouth not definitive, these data emphasize the importance of both professional and lay education if we are to bring the majority of the hypertensive population under control.

TABLE I
EFFECT OF DETECTION AND ADVICE TO SEEK TREATMENT FOR HYPERTENSION—WITH AND WITHOUT SUPERVISION

	Advice Only — No Active Supervision		Supervision during Study (Home Visits by Nurse)	
	% *UNDER RX*	% *GOOD CONTROL*	% *UNDER RX*	% *GOOD CONTROL*
At Beginning of Study	25	15	25	15
After 2 Years of Study	50	34	86	80
2 Years After End of Study	35	21	55	29

(Adapted from Wilber and Barrow)

The Therapeutic Program

The American Medical Association Committee on Hypertension recommends that all patients with persistent diastolic pressure of 105 mm Hg or higher should receive antihypertensive therapy. The committee recommends that patients with a diastolic pressure below 105 mm Hg but more than 90 mm Hg be kept under continuous surveillance, and whether or not they are to receive antihypertensive therapy shall depend on the medical evaluation and opinion of the physician.

Prior to beginning a course of life-long treatment, the patient with mildly to moderately elevated blood

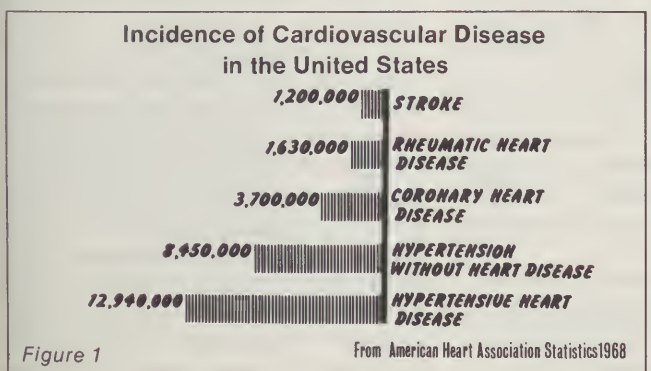


Figure 1

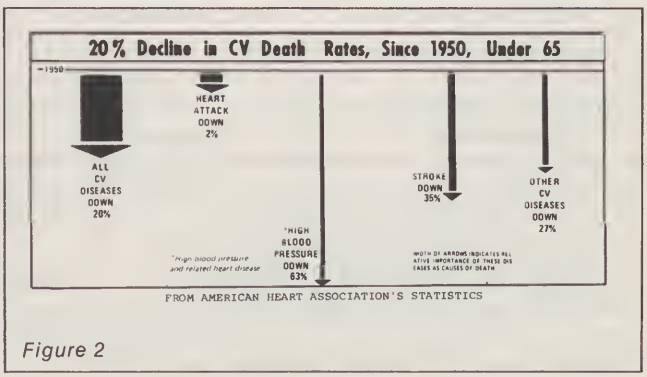


Figure 2

pressure should be seen on at least three separate visits to determine whether the blood pressure is persistently elevated. The extent of organ changes, particularly those affecting the optic fundi, brain, heart, and kidneys, should also be assessed. The objective of treatment is to lower the blood pressure to normal or to the lowest level that the patient will tolerate. Usually levels of 150/100 mm Hg or lower in the standing position may be achieved without prohibitive untoward effects; a blood pressure of 140/90 is desirable. Because individual responsiveness differs, the regimen must be individualized to control the hypertension with minimal adverse reactions. To achieve this, it is often necessary to try various single drugs or combinations at different dose levels until the optimal effect is obtained.

Diuretics

For patients with mild or moderate hypertension (diastolic blood pressure below 120 mm Hg), treatment is usually initiated with an oral diuretic—(see Table II and Figure 3). The diuretic may control the blood pressure without additional therapy. Even if it is not effective alone, it provides a useful medication to counteract sodium retention and enhance the antihypertensive activity of other agents which are added later, such as a rauwolfia alkaloid, methyldopa (Aldomet® Merck Sharp & Dohme), or hydralazine (Apresoline® Ciba Pharmaceutical Co). All of the diuretics referred to in Table I are about equally effective. (The table is adopted from "Drug Evaluation," which lists diuretics available and compares dosages required for equivalent antihypertensive effect.) After the maximum blood pressure reduction from the diuretic has been evaluated, the minimum dose which maintains the achieved blood pressure reduction should be continued. This is usually 50 mg of hydrochlorothiazide per day or its equivalent in the other diuretics.

TABLE II

ORAL DIURETIC AGENTS USEFUL IN THE MANAGEMENT OF HYPERTENSION

Drug	Trade Name and Tablet Size (mg)	Usual Daily Dose* Initial	Maximal	Minimum ≠	Side Effects
Sulfonamide Derivatives Benzothiadiazines: Chlorothiazide	Diuril 250-500	1000**	1500**	500	Serum electrolyte disturbances (usually asymptomatic): 1. urea-increased 2. uric acid-increased 3. potassium-decreased 4. calcium-increased 5. glucose-increased Gastrointestinal irritation, weakness, dry mouth, leucopenia, anemia, thrombocytopenia, purpura without thrombocytopenia, skin rash, photosensitivity, temporary deafness in azotemia (ethacrynic acid only)
Hydrochlorothiazide	Hydrodiuril 25-50 Esidrix 25-50 Oretic 25-50	100**	150**	50	
Hydroflumethiazide	Saluron 50	100**	150**	50	
Bendroflumethiazide	Naturetin 2.5-5	10	15	5	
Trichlormethiazide	Naqua 2-4 Metahydrin 2-4	4	8	4	
Methyclothiazide	Enduron 2.5-5	10	15	5	
Benzthiazide	Exna 50	100**	150***	50	
Polythiazide	Renese 1-2-4	2	8	2	
Cyclothiazide	Anhydron 2	2	6	2	
Anthranilic Acid Derivative: Furosemide	Lasix 40	80**	160***	40	
Phthalimidine Derivative: Chlorthalidone	Hygroton 50-100	50	100	50	
Quinazoline Derivative: Quinethazone	Hydromox 50	100-150**	150**	50	
Phenoxyacetic Acid Deriv.: Ethacrynic Acid	Edecrin 25-50	100**	200***	50	Hyperkalemia, gynecomastia, drowsiness, mental confusion, hirsutism, irregular menses, rash, headache, diarrhea, ataxia
Distal Tubular Diuretics Spironolactone	Aldactone 25	100***	400***	50	
Triamterene	Dyrenium 100	100	300**	50	Hyperkalemia, diarrhea, nausea, vomiting, dry mouth, headache, photosensitivity, rash

* Given once daily unless otherwise indicated.
** Usually divided and given twice daily.
*** Usually divided and given four times daily.
≠ Considered minimum effective antihypertensive dose for maintenance therapy.

(Adapted from *AMA Drug Evaluations, Second Edition)*

REGIMENS FOR THE MANAGEMENT OF UNCOMPLICATED HYPERTENSION

Severity	Mild (90 - 120)			Moderately Severe (121 - 140)	Severe (more than 140)
Diastolic Blood Pressure (mm. Hg)	Alternative #1*	Alternative #2	Alternative #3		
Initial Therapy	Diuretic	Diuretic	Diuretic	Diuretic	Diuretic plus Guanethidine
Supplemental Therapy - A	+ Reserpine	+ Methyldopa	+ Propranolol**	+ Guanethidine	+ Methyldopa
Supplemental Therapy - B	+ Hydralazine	+ Hydralazine	+ Hydralazine	+ Methyldopa	or Hydralazine
Supplemental Therapy - C	Alternative #3	Alternative #3	—	or Hydralazine plus Propranolol**	+ Propranolol**
Remarks	—	—	—	—	Ganglionic Blockade If Necessary

Figure 3. Overall Prescription Plan *When Tranquilizer Indicated **Experimental - Not FDA approved

Ethacrynic acid or furosemide may also be used in the treatment of hypertension, but these should be reserved for special circumstances wherein the more potent natriuretic effect is desired, with shorter duration of action.

Patients receiving long-term diuretic therapy must maintain adequate potassium intake. In patients who have no evidence of heart failure, and in whom kidney function is adequate, this can usually be guaranteed by a diet containing a liberal amount of high potassium foods. However, the plasma potassium should be monitored as often as necessary in order to evaluate the stability of the potassium level, especially during the first year of therapy. If total body potassium deficit becomes a problem, as evidenced by a plasma potassium of 3 mEq per liter or less, then one of the potassium-sparing agents should be added to the regimen: spironolactone (Aldactone® G.D. Searle and Co.) or triamterene (Dyrenium® Smith, Kline and French Labs.). The potassium-sparing diuretics are particularly indicated for patients with heart failure since such patients tend to become depleted of potassium more readily than others and are more likely to have a total body deficit. If significant total body deficit of potassium continues, oral potassium supplements may be added to the regimen. Under these circumstances, the supplementary intake should usually be 100 mEq or more per day. The plasma potassium should be maintained above 3.5 but below 6.0 mEq per liter in order to avoid the development of hyperkalemia and its subsequent cardiac effects.

An alternate approach is to use a fixed diuretic combination of a thiazide with either triameterene or spironolactone. This is a valid approach and certainly may be tried in the absence of renal damage and severely depressed renal function. This is particularly important for the patient who is taking digitalis.

Side effects of the diuretics, other than electrolyte abnormalities, are most frequently due to vascular fragility resulting in ecchymosis and subcutaneous hemorrhage, or abnormalities of the hematopoietic system such as thrombocytopenia and hemolytic anemia. Occasionally skin eruptions and photosensitivity are observed.

The response to the diuretic should be observed for a period of at least two weeks. Then, if additional reduction in blood pressure is indicated, one of the agents with antihypertensive activity affecting the sympathetic nervous system or the blood vessel directly should be employed (Figure 3 and Table III). These drugs should always be given in conjunction with a diuretic since the diuretic reduces the dose requirement of the sympathetic depressant drugs and also reduces tolerance to these drugs in many instances. It also helps to counteract the increased sodium retention and plasma volume that may result from long-term administration of the sympathetic depressant drugs.

Alternatives

Possible drug regimens (Figure 3) are as follows:

Alternative No. 1: In treating patients for whom sedation and a mild tranquilizer are indicated, the choice of combination therapy may be reserpine (0. 1-0.25 mg per day) given in combination with the diuretic. The reserpine has a delayed onset of action and maximum response. Frequently its full effect is not observed until the patient has been on the drug for as long as six weeks. Therefore, patients started on this combination should be observed for a minimum of six weeks before other drugs are added to the regimen.

Psychic depression is the most serious side effect resulting from rauwolfia administration. Nasal turgescence is consistent and annoying, but not a serious side effect. The nasal decongestants are effective against this but should not be used too frequently. Oxymetazoline HC1 (Afrin® Schering Corp.) is particularly good because of its long duration of action.

Alternative No. 2: Diuretic plus methyldopa (Aldomet®). Most patients for whom a sedative (tranquilizer) is undesirable can be given methyldopa in combination with a diuretic. The initial dose is 250 mg each morning, and daily dosage can be increased by 250 mg each week until adequate reduction in blood pressure is observed. Doses in excess of 2000 mg per day are usually not employed. The drug can be given in multiple doses throughout the day or as a single dose in the morning, whichever is tolerated best.

Although somnolence may be observed when methyldopa is given initially or when the dose is increased, this is usually transient and rarely persists for more than three or four days. Probably the next most frequent side effect from methyldopa is a positive direct Coombs test, although frank hemolytic anemia is uncommon. An occasional patient has been observed to develop toxic drug psychosis associated with drug fever.

Hydralazine (Apresoline®) can be added to either one of the above drug combinations—i.e., alternative No. 1 (diuretic-reserpine) or alternative No. 2 (diuretic-methyl-

TABLE III

ANTIHYPERTENSIVE DRUGS

Drugs	Trade Name & Tablet Size (mg)	Usual Daily Dose (mg*) Initial	Maximal	Side Effects
Sympathetic Depressants Rauwolfia = Reserpine (Single Alkaloid)	Serpasil 0.1, 0.25 Sandril Reserpoid	0.1	0.25	Drowsiness, sedation, lassitude, nasal congestion, myalgias, edema, laxation, bradycardia, depression, gastric hyperacidity, nightmares, Parkinsonian rigidity
Whole Root	Raudixin 50, 100	100	300	
Alseroxylon Fraction	Rauwiloid 2	2	4	
Methyldopa ≠	Aldomet 250	500 ≠ ≠	2000 ≠ ≠	Orthostatic hypotension (rare), drowsiness, dry mouth, fever, nasal congestion, depression, abnormal liver function tests (with or without jaundice), positive direct Coombs test, usually without hemolytic anemia
Ganglion blocking agents Pentolinium	Ansolysen 10,20,40,100	40**	No limit***	Orthostatic hypotension, dry mouth, blurred vision, constipation, urinary retention, impotence
Mecamylamine	Inversine 2.5, 10	5	No limit**	
Guanethidine sulfate ≠	Ismelin 10, 25	10	No limit	Orthostatic hypotension (esp. in A.M.), exertional weakness, bradycardia, diarrhea, nasal congestion, impotence or loss of ejaculation or both
Pargyline	Eutonyl 10, 25	10	No limit	Orthostatic hypotension, nausea, vomiting, insomnia, nervousness, impotence or loss of ability to ejaculate or both, urinary retention, hypertensive crisis after ingestion of foods containing tyramine, (certain cheeses, beers, wines, pickled herring).
Propranolol	Inderal 10, 40	80**	320***	Nausea, vomiting, light-headedness, depression, constipation or diarrhea, fever, rash, thrombocytopenia, CONGESTIVE HEART FAILURE, aggravation of bronchial asthma and peripheral ischemia
Vasodilator = Hydralazine hydrochloride	Apresoline 10, 25, 50, 100	50**	300***	Headache, tachycardia, palpitations, fever, nausea and vomiting, flushing, exacerbation of coronary insufficiency or congestive heart failure, toxic psychosis, mesenchymal ("lupus") reaction

* Give once daily unless otherwise indicated
** Usually divided and given twice daily
*** Usually divided and given four times daily
≠ Most frequently used drugs
≠ ≠ Methyldopa may be given either as a divided dose or as a single dose in the morning

(From *AMA Drug Evaluations, Second Edition*)

dopa)—if adequate reduction in blood pressure has not been observed at maximum dosage or when significant drug side effects are observed (Figure 3). It is better tolerated and probably is more effective when used with these agents than when used alone. The length of action of this drug is no more than four to six hours, and therefore it must be given at regular intervals throughout the day. This short period of action makes it valuable as an additional therapeutic agent to be used with the above programs for those patients whose blood pressure becomes sharply elevated at regular times during the day. The initial dose is 10 mg, and this can be increased in 10 mg increments.

When therapy with hydralazine is initiated or the dose is increased, headache and tachycardia may be observed. If these side effects become prohibitive, the dose should be reduced. Patients with a history of coronary artery disease, especially if they have had a myocardial infarction, should not be given hydralazine. The dose should not exceed 200 mg per day because a lupus-like syndrome, hydralazine disease (Table III and Figure 3), develops when larger doses are used.

In some patients with obvious manifestations of anxiety and neurosis, tachycardia and clinical manifestations of intermittent increase in cardiac output may be a problem. For these a beta adrenergic blocking agent, propranolol (Inderal® Ayerst Labs.) may be useful (Alternative No. 3). This is especially true of patients with angia and those on whom hydralazine has a significant cardiac stimulant effect. Patients who appear to be unresponsive to alternatives No. 1 and No. 2 above may also be helped by the addition of propranolol and switching to alternative No. 3, especially those in whom sympathetic cardiac effect is apparent. The initial dose is 10 mg given four times a day; it is usually not helpful to employ doses in excess of 320 mg per day (Table III).

Alternative No. 3: For patients with severe hypertension (diastolic blood pressure 120 mm Hg or more) but without retinal exudates and hemorrhage, a diuretic plus guanethidine (Ismelin® Ciba Pharmaceutical Co.) is usually effective. However, the orthostatic hypotension produced by guanethidine may be troublesome, and the dose must be carefully adjusted. In this therapeutic regimen, the diuretics are used as described above for mild hypertension. Then, after the response to the diuretic has been evaluated, the guanethidine is started. (Patients whose pretreatment diastolic pressure is more than 140 mm Hg should be started on the diuretic *plus* guanethidine initially, rather than the diuretic alone, followed by guanethidine.) A dose of 12.5 mg per day is employed initially, and this is increased by 12.5 mg at weekly intervals until the blood pressure is reduced to the desirable degree with the patient in the standing position.

For those patients in whom excess orthostatic effect is observed, or in whom the side effects become excessive without an adequate reduction in blood pressure, the dose of guanethidine may be maintained at the tolerable level and methyldopa added to the drug regimen. The methyldopa is titrated as described previously for mild hypertension, thus attempting to attain additional reduction of the blood pressure without intolerable side effects. Hydralazine may also be used in combination with guanethidine, rather than methyldopa, and administered as previously described. Or sometimes, in obstinate cases, hydralazine may be added to the triple regimen of diuretic, guanethidine, and methyldopa.

The most troublesome side effect of guanethidine in the male is retrograde ejaculation into the bladder with orgasm, because of internal sphincter relaxation and external sphincter contraction. Diarrhea can be a troublesome side effect also as the sympathetic nerve impulses to the gut are suppressed, leaving the parasympathetics unopposed. Atropine or tincture of belladonna may be used in a titrated dose until this side effect is overcome.

Occasionally patients with severe disease cannot be controlled on any of the above drug regimens. Under these circumstances a ganglionic blocking agent may be employed, such as mecamylamine hydrochloride (Inversine® Merck, Sharp, & Dohme). When this is done, a single dose in the morning is usually effective; the initial trial dose is 2.5 mg, and it is increased by 2.5 mg per day at intervals of two or three days. The addition of this agent is particularly helpful for those patients who experience persistent diarrhea when taking guanethidine and in whom a cholinergic blocking agent is ineffective, since the dose of guanethidine may be reduced and the antihypertensive effect may be maintained with the mecamylamine. At the same time, the significant side effect of mecamylamine is to reduce peristalsis, and this side effect may be used as a therapeutic advantage in counteracting the distressing side effect of guanethidine (diarrhea) while maintaining adequate blood pressure control.

Effect of Therapy on Prognosis

The reduction in longevity due to essential hypertension is directly proportional to the severity of the blood pressure increase, and the prognosis for the treated patients is most dramatically altered in those more severly afflicted. In fact, improvement in mortality and morbidity is directly related to the adequacy of therapy. Perhaps the best summary of the effect of therapy of hypertension is available in an article on a study by the Veterans Administration Cooperative Study on Hypertensive Agents.[2,3] Three hundred and eighty male hypertensive patients with diastolic pressures averaging 90 to 114 mm Hg were randomly assigned to either active antihypertensive agents or placebo. The estimated risk of a morbid event occurring over a five-year period was reduced from 55 percent to 18 percent by treatment. Terminating morbid events—which included those serious enough to necessitate removal of patients from the study as well as deaths—occurred in thirty-five patients of the control group. Nineteen deaths related to hypertension or atheros-

TABLE IV
EFFECTS OF TREATMENT ON PROGRAMS
(301 Patients)

Diastolic Blood Pressure (mm Hg)	Death in Less than 5 Years (% of Patients)	
	Treated	*Untreated*
100-120	7	15
120-140	13	38
More than 140	19	59

clerosis occurred in the control group and eight in the group treated with active drugs.

In addition to fifty-six patients in whom both terminating and non-terminating morbid events occurred, there were twenty control patients who developed persistent diastolic levels of 125 mm Hg or higher. Treatment was more effective in preventing congestive heart failure and stroke than in preventing the complications of coronary artery disease. The degree of benefit was related to the level of pretreatment blood pressure, being most evident in the patients with initial diastolic pressures above 105 mm Hg.

From the above studies several very important conclusions can be drawn. The first is that the incidence and severity of coronary artery disease is not particularly affected by blood pressure regulation. This is basically a disease of

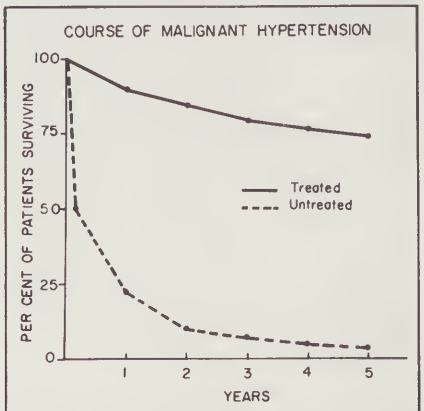


Figure 4. In a group of patients with malignant hypertension followed for five years, only 25 percent of those treated had died at the end of the follow-up period, while nearly all of the untreated patients had died. Renal failure was the leading cause of death in the control group (From Moyer, J. H. and Flynn, J.: Role of arterial hypertension in coronary atherosclerosis, in Russek, H. I. and Zohman, B. L. (Eds.): Coronary Heart Disease. *J. B. Lippincott Co., Philadelphia, 1971, pp. 137-145.)*

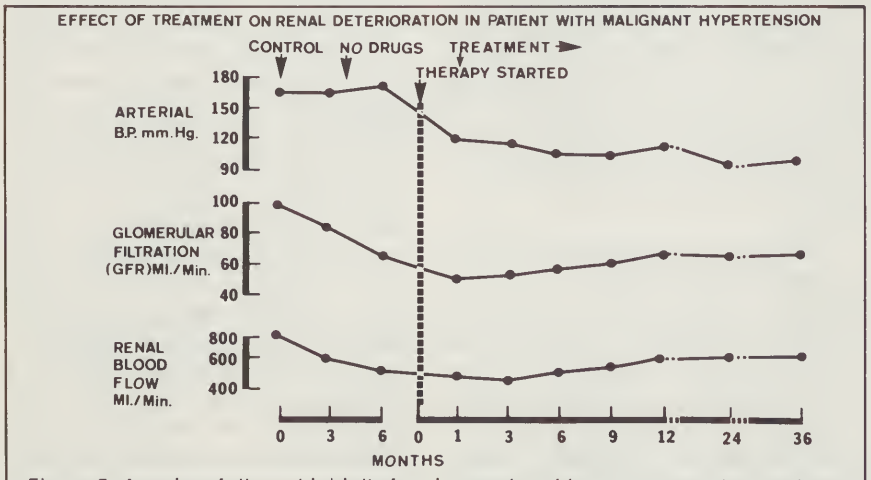


Figure 5. A patient followed initially for six months without treatment had a 50 percent loss of renal function at the end of that time. After treatment was started and the blood pressure reduced, the deterioration of renal function was arrested except for a slight additional loss of function at first due to the initial decrease in renal perfusion resulting from the lowered pressure. A small degree of improvement in renal function was noted at the end of one year on antihypertensive medication, but full restoration cannot be expected because kidney damage existing at the time treatment is initiated is irreversible.

atherosclerosis. Myocardial infarction occurs in the normotensive person as well as in the hypertensive. Therefore, in this instance blood pressure reduction is not directly related to prognosis and mortality as it is in the case of other atherosclerotic complications, such as cerebrovascular accidents, in which the blood pressure elevation is more directly related to the vascular disease and its complications.

Most important of all, however, is that despite the severity and complications of hypertension, patients with the most severe disease receive the greatest benefit of treatment, though the mortality is also reduced in the patients with less severe disease. The difference is even more striking when results of a previous study on effects of treatment in patients with initial diastolic pressures of 115 to 120 mm Hg[3] are compared with the results of this study. In the earlier study, morbid events occurred thirteen times as frequently in the control group as in the treated patients.

It is also evident that blood pressure elevation increases in severity with time. Therefore, we can conclude that the earlier treatment is instituted, the better the prognosis.

In a study conducted by the author, approximately 340 patients with various degrees of hypertension were observed. Of 340 patients entered into the study, only 30 continued to the end; and of the 301, differential renal function studies employing inulin clearance were done on 129.[4] Those dropping out of the study were about evenly divided between the treated and the untreated patients. Referring to Table IV, it can be observed that no matter whether the patients were treated or untreated, the prognosis was poorer when the diastolic pressure was higher. Nonetheless, it is obvious that blood pressure reduction by antihypertensive drug therapy was effective in improving the prognosis in all groups of patients. Again, one can conclude that the sooner the blood pressure is reduced, the better the prognosis.

TABLE V

CAUSE OF DEATH IN 12 OF 48 PATIENTS TREATED FOR MALIGNANT HYPERTENSION

Year	Renal	Cerebrovascular Accident	Coronary
First	2	1	—
Second	1	1	1
Third	—	2	—
Fourth	—	1	2
Fifth	—	—	1
Total*	3	5	4

*Mortality after 5 years due to hypertension.
Unrelated causes of death—3 patients.

Malignant Hypertension

Now let us consider those most severely hypertensive, the patients with malignant hypertension. Here the effect of treatment is quite dramatic. As can be see from the five-year follow-up of untreated patients (Figure 4), the prognosis is zero. With treatment, the mortality can be reduced to 25 percent with adequate blood pressure regulation. The greatest factor in mortality is renal damage. Figure 5 is a clear example of how blood pressure control arrests renal deterioration.

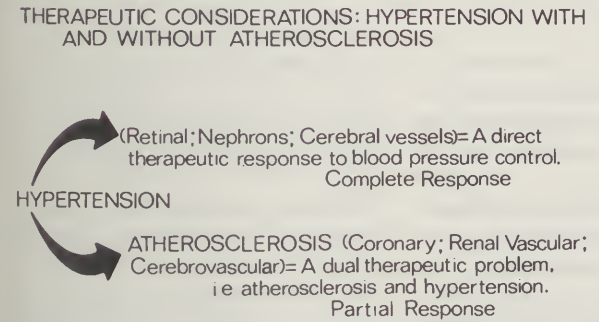
Equally as important as the observations on mortality of patients with malignant hypertension is what occurs with these patients when they are converted to a milder type of hypertensive diathesis—i.e., the blood pressure is regulated but the basic hypertensive phenomena exist and frequently the blood pressure does break through drug control. Of forty-eight patients with malignant hypertension, twelve died over a five-year period (Table V). Initial deaths were due to renal failure, whereas those after the second year were due to atherosclerotic complications. These patients, then, had been converted to a milder hypertensive state, and atherosclerosis became the predominant determinant of prognosis.

Associated Atherosclerosis

Atherosclerosis occurs not only in the patient with hypertension but in the normotensive patient as well; in fact, it causes occlusive lesions (i.e., thrombosis) in the normotensive state in patients who have never had hypertension. Hypertension merely accelerates the development of the atherosclerosis and makes it more likely that thrombosis or even rupture of the vessel will occur during sudden increases in the blood pressure. However, the hypertension is only a complication of this diphasic disease, and even though that component of the morbidity and mortality due to blood pressure elevation is removed by controlling the blood pressure, the basic atherosclerotic disease progresses (Fig. 6).

Until atherosclerosis as such can be better treated, it is not likely that we will significantly alter the prognosis, the morbidity, and the mortality in these patients. When occlusive disease of the renal artery is diagnosed, more than 50 percent of

Figure 6. It is significant that the most severe hypertension, which is associated with small vessel disease, can be readily controlled by blood pressure regulation, which results in arrest of the vascular deterioration. When, however, atherosclerosis becomes a primary problem, alteration of the morbidity course with blood pressure regulation is not very significant since here the primary cause of morbidity and mortality is atherosclerosis rather than the blood pressure elevation.



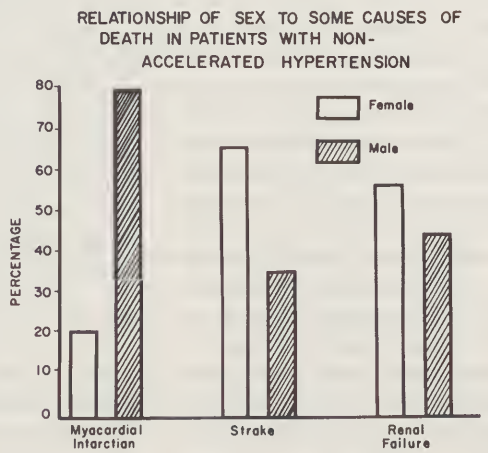


Figure 7: Reflecting the greater vulnerability of the male to atherosclerotic changes in mild to moderate hypertension, deaths from myocardial infarction among men are four times as frequent as in women. The greater incidence of cerebrovascular accidents as a cause of death in the female hypertensive may indicate an increased incidence of atherosclerosis of the cerebral vessels, followed by thrombosis, which usually occurs with sharp elevations of the blood pressure. This ratio of greater incidence of myocardial infarction in the male as compared to the female also exists in the normotensive population. (Reproduced from Moyer, J.H. and Brest, A.N.: The changing outlook for the patient with hypertension. Am. J. Cardiol. 17:673-681, 1966.)

the patients are found to have multicentric disease—either multicentric areas in the same artery or lesions on the opposite side. Furthermore, 75 or 80 percent of these patients have associated coronary artery disease as evidenced by changes in the electrocardiogram, and 25 percent have associated carotid disease.

Some collected observations by Beem[5] summarize the relation between male and female patterns of hypertension. The relatively greater frequency of atherosclerosis in the male hypertensive is quite evident (Fig. 7). There is a ratio of 4 to 1 in which coronary artery disease is a cause of death. In both male and female the incidence was four times as great in the hypertensive as compared to the normotensive (not shown on the graph), so that a ratio of 16 to 1 existed when the hypertensive male was compared with the normotensive female.

The Patient with Renal Damage

In the patient with papilledema and blood pressure elevation and secondary renal damage to the glomeruli, the blood pressure elevation is directly related to the glomerular damage and fibrinoid changes in the nephrons. The sooner treatment is instituted, the better for the patient. However, in some patients the blood urea nitrogen is elevated and evidence of excretory failure has already occurred before the patient is brought under therapy. If the blood pressure is not reduced and controlled adequately, the disease progresses with the usual fibrinoid and associated pathological changes in the kidney. On the other hand, when the blood pressure is reduced there is an additional reduction in filtration rate on a hemodynamic basis, aggravating the renal excretory failure.

The only approach to this problem is to gingerly reduce the blood pressure as far as can be tolerated hemodynamically by the patient. Best results are achieved through the use of parenteral methyldopa. When this drug is administered, it maintains cardiac output, thus permitting the maintenance of renal blood flow so that there is less reduction in glomerular filtration rate than is observed with the other antihypertensive agents for an equivalent reduction in blood pressure. As soon as the blood pressure has been reduced for ten days to two weeks and the renal hemodynamics have become adjusted, then the parenteral methyldopa is gradually withdrawn and the usual oral antihypertensive measures are instituted, consisting of a diuretic and more potent drugs, such as guanethidine.

After the blood urea nitrogen is elevated, however, the prognosis is much poorer even with adequate blood pressure regulation. Nevertheless, the only way to offer the patient any future at all is to try to control the blood pressure to the maximal degree that he can tolerate, following the blood urea nitrogen carefully.

Renal function is also reflected in mortality. If the blood pressure is treated early enough, before renal damage is significant, the mortality is reduced markedly. It can be seen in Table V that, of those patients who died in the first two years, a significant number died of renal failure caused by progression of the renal damage, indicating that therapy had not been instituted early enough. Of the patients who died after two years, however, all died of a complication of atherosclerosis. Here the hypertension was merely a complicating phenomenon and not the direct cause of progressive renal disease, as is seen in untreated malignant hypertension.

Summary

The control of blood pressure is quite possible if one pays strict attention to pharmacodynamics of the drugs, the proper selection of a drug, and some basic principles related to drug administration, particularly of the autonomic drugs.

Diuretics are cornerstones of antihypertensive therapy. They not only have some antihypertensive properties in their own right, but in addition they prevent the development of tolerance to other drugs such as methyldopa. They also decrease the dose requirement of the more potent antihypertensive drugs, thereby decreasing side effects due to the latter agents.

In the patient whose blood pressure is not so severely elevated, atherosclerosis and fluctuating blood pressure may become the predominant determinant of morbidity and mortality. Under these circumstances, the hypertension is merely a complicating phenomenon, and controlling the blood pressure only removes that component of the morbidity determinant related to blood pressure elevation; it does not affect the basic morbidity and mortality related to the atherosclerotic disease. In these patients the primary problem is that of occlusive lesions of the diseased, atherosclerotic vessel.

If treated early enough, the small vessel disease of malignant hypertension can be completely arrested. However, atherosclerotic disease later becomes manifest and then becomes the primary disease even in well-controlled patients. Eventually many of these patients will die of atherosclerotic disease even if the blood pressure is regulated at the normotensive level.

It cannot be sufficiently emphasized that in the therapeutic management of hypertension probably the most important single consideration, yet the most frequently overlooked, is that of appropriate dose titration, in which the dose of the sympathetic depressant drug is adjusted exactly to the requirement of the individual patient for blood pressure regulation. □

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practice management

Renting? Read this!

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A high percentage of medical practices work out of leased offices. Since well-managed practices will typically pay rent of anywhere from 4 to 8 percent of their gross income (a fairly significant amount) the doctors involved should give attention to the details of the document obligating them to the arrangement—the lease. Nevertheless, both when they move into newly rented offices and when they renew existing rental arrangements, doctors often seem to have no real idea what the lease provisions really mean to them. For these reasons, I hope the following brief comments about typical lease terms and attitudes might be helpful.

General negotiating attitude—First and foremost, any doctor contemplating entering a lease should have the document reviewed carefully by an expert advisor, typically an attorney. Even standard preprinted form leases tend to vary rather dramatically, and what actually appears therein can become of vital importance as various developments later unfold. As an example, a real estate agent's friendly comment that the landlord is flexible and will provide services or improvements not stated in the lease are worthless, for the finally signed document prevails in setting forth what each party's rights and obligations really are. An attorney will understand what that document actually provides in questionable areas and can check any all oral promises against the document for consistency.

Furthermore, I have found that a medical practice can often obtain favorable provisions not existing in the originally offered lease. Landlords tend to be fairly reasonable and should be particularly so if their buildings are not yet fully leased out. A variety of special arrangements such as options to renew, individualized "escape clauses," and the like may be extremely important to the practice moving into the office—and in many cases will not be that adverse to the landlord. Having an attorney or other advisor who understands these ideas and can express them to the landlord should be well worth any fees involved.

Actual rental rates—There really is no common figure on what is a "proper" per square foot rental rate. I have seen rents as low as $3 per square foot and as high as $15 per square foot, and in each case the doctor involved felt the rate was reasonable for his purposes. What is probably more important is that the space properly accommodates the practice and that the total rental paid fits in with a fair projection of the year's gross income. Rental rates are, by the way, typically stated as annual amounts to be paid for each square foot of space rented, in which case a 1,000 square foot office at $6 per square foot would result in annual rent of $6,000, or $500 per month.

Along these lines, perhaps the worst mistake a practice could make is to turn down a desirable office opportunity because the rent seems too high. In the long run, the rent will continue unchanged as the practice's gross income increases so that it should be a constant in an otherwise increasing set of numbers. Furthermore, compared to some other elements of overhead (particularly the cost of personnel), office rent tends to be quite low. Too many practices cling to working in less than suitable or efficient quarters, perhaps having fewer examining rooms than really necessary and/or keeping substandard business office space, to the point that they become unable to operate efficiently. These are obviously false economies when they interfere with the opportunity both to treat the most patients effectively and the opportunity to increase their incomes.

In considering whether the suggested per square foot rental rate is appropriate, several misleading possibilities should be noticed. First, is the landlord quoting the rent for all protions of an area including unusable space such as hallways, elevator areas and the like? If so, then the "true" rent per usable square foot of space is obviously somewhat higher than the stated rate. Second, does the rental rate include or exclude the landlord's payment of utilities? If the tenant is expected to pay such charges as electricity, heat and water, then the true rent is obviously somewhat higher than quoted. These are important points to note when comparing the rental rates of two or more offices under active consideration.

Length of lease—In my view, practices tend to make mistakes by entering into long-term leases. This is often true even though the longer term undertaking appears to guarantee a constant rent which diminishes in "real dollars" as inflation raises the cost of all other items. The reason is simply that as medical practices tend to grow, whether by adding more doctors or assistants or by expanding each doctor's own patient volume, the selected office needs tend to change. Similarly, practice patterns may change over the years, including such possibilities as the doctor's changing his primary work to a different hospital and/or the patient load beginning to come from a different area.

Because of these concerns, I believe that a fairly short-term lease is far preferable even if it might result

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in an increased rental rate if the lease term expires and the lease is renewed. It is far better to accept the increasing lease obligation, probably merely paralleling inflation and to have the flexibility to practice in the most desirable and efficient quarters—to avoid being "locked in" to an office which has become unsatisfactory.

A very desirable approach towards obtaining reasonable rental rates over an extended period without losing flexibility would be to obtain several "options to renew" the lease. For instance, I believe a three-year lease with two successive options to renew for three years each at rental increases of perhaps $.50 per square foot with each renewal would be preferable to a single nine or ten year lease at a lower constant rate. The option to renew merely gives the tenant (the medical practice) a *choice* at the end of the lease term either to continue renting the office for an additional period or else to move out with no penalty.

Escalation clauses—Office leases are increasingly including provisions calling for the rent to escalate in some predetermined manner over the lease term. These are known as "escalator clauses," and I do not consider them absolutely undesirable so long as they are tied to reasonable measures. For instance, a landlord might well be justified in increasing the rent because certain real estate taxes or utility charges force his own costs to increase beyond what he had anticipated.

Some leases tie the rent to the general cost of living by calling for increases directly in proportion to the "consumer price index" increases. I do not think this is a desirable arrangement, as the last few years of inflation would demonstrate, and a doctor should usually be able to avoid this proposition. Escalator clauses tied to increasing real estate taxes and utility charges, on the other hand, are quite common but must be very carefully reviewed to assure that the "base rentals" are fair. For instance, if the tenants are to share any increases in a new building's real estate taxes, one must be careful that the base tax figure was assessed on a valuation for the building in *completed* form. Since tax assessment on new buildings often lag as much as a year beyond completion, one can see the trap that could exist. The same is true with escalator clauses tied to utility charges if during the base period the building was not yet fully occupied—the trap being that the total utility charges would obviously be lower than when all tenants have moved in.

Escape clauses—Especially in the case of a solo practice it is extremely important that the doctor's lease provide some opportunity for termination in case of his death, long-term disability, or call to military service. Without such an "escape clause" the doctor or his estate could be liable for continuing rent even for years after his untimely absence or death. Landlords are often receptive to some type of provision permitting a solo doctor to terminate the lease after pehaps three months' or six months' notice in the event of such named occurrences beyond his control.

Solo practicing physicians who have incorporated should also recognize the need for a power to terminate in case of death or other event. Although the tenant named in the lease should properly be the corporation rather than the doctor, the escape clause could still tie to the doctor as the tenant's sole source of income.

An alternative to the escape clause, though not as satisfactory, would be the right to sublet the office. Landlords will often insist on the right to approve any person to whom the premises might be subleased, and this can lead to troublesome problems. If the building is not fully rented when the sublease situation arises, a londlord will obviously not be very receptive to a tenant's subleasing to someone who might otherwise become a direct tenant. Nevertheless, as a minimum, one might press for the right to sublet to any other health-related persons or businesses either without landlord approval or with a provision that the landlord's approval "shall not be unreasonably withheld." While this language may be difficult in application, it is better than no right to sublet at all.

Tenant improvements—An area of extreme delicacy in any lease is who shall bear the cost of improving the premises. This is particularly true if a practice is moving into a new building, for there may be extensive costs of installing partitions and plumbing to suit the new practice, laying out new electrical outlets and lighting arrangements, installing new cabinetry and equipment, and the like. If the tenant is required to make many of these physicial improvements at his own cost, then in effect his total rental outlay will be substantially higher than the quoted per square foot rate. On the other hand, a landlord who offers to assume the cost of these improvements has probably already figured that cost into the monthly rental rates. Comparison, therefore, becomes important but sometimes difficult.

Improvements also can cause problems when the tenant moves out of the office. Will the practice, for instance, be entitled to remove certain cabinetry built in especially for that practice, will certain equipment affixed to the walls or floor be removable? If there are any doubts about these matters, and in fact if there are any improvements even arguably to be affixed, I would urge that they specifically be expressed in the lease document with provisions allowing their removal upon lease termination.

Removal of improvements may very well damage the existing walls or flooring. If the tenant anticipates such a problem, it should also be negotiated when the lease is being entered.

Parking—Since adequate parking space is of prime importance to a medical office, a doctor should be careful that the lease assures the continuing maintenance of such space. It is not unusual for owners to expand their buildings (or build entirely new buildings) on what was previously parking area, in which case the desirability of the office itself might become seriously damaged. The problem might be avoided by insistence on a lease provision that the owner will maintain either the same parking area he already has laid out or else

that he will maintain a specified ratio of parking spaces to each rental unit.

Practice Limitations—One must be very careful to determine whether the preprinted lease "rules and regulations" might prohibit certain activities which the doctor might decide to engage in. Typical of such restricted activities would be installation and use of X-ray machinery and/or of laboratory facilities. While X-ray facilities obviously raise the fear of radioactivity, whether or not justifiable in a medical office, they may also require special structural support. Therefore, if there is even the outside possibility that such machinery might be added to the practice in the future, I would suggest that the tenant inquire into the building's capacity to hold it and also that he seek specific permission in the written lease.

Redecoration, repainting, and recarpeting—Some landlords orally express a policy of redecorating and repainting tenant offices periodically, perhaps every three years or five years. The expression, however, is meaningless unless it also appears in the lease document. Without it, the tenant may find that he has no real lever to obtain these benefits except the threat to move out as the lease term approaches its expiration date.

More and more offices are being contructed without finished flooring so that wall-to-wall carpeting is initially provided. While this may be desirable, one must recognize that carpeting tends to wear out in just a few years with the resulting need to be replaced. Particularly since the underlying flooring may not be satisfactory without carpeting, I urge that the tenant seek an express lease undertaking that the owner will replace the carpeting perhaps every five years. This provision can lead to a considerable saving for the medical practice tenant.

Summary—The above are a few of the common areas in which a proposed office lease might become a serious problem for the medical practice. With reasonable care in reviewing the lease and in negotiating with the owner, however, the problems should be capable of solution. Hopefully by these descriptions the reader will be more aware of what he and his advisors should protect against as he considers moving into his new office or renegotiating the lease on his present space.

House position emphasizes teamwork

The 1973 House of Delegates adopted the following position paper on nursing and the coordinated and cooperative team effort which must exist between physicians and nurses. This adoption makes it the official policy of the State Society.

"1. The best possible health care of our fellow human beings is the reason for the existence of, and should be the primary goal of, the professions and technologies concerned with all facets of health. Therefore, the interest of the patient must be the major consideration in all decisions made by either the Pennsylvania Commission on Nurse Education or the Pennsylvania Joint Practice Commission concerning the future of nursing in Pennsylvania.

2. The delivery of optimum health care is a coordinated and cooperative team effort. The physician who has the legal responsibility for patient care must be the leader of the team. Nursing and all other patient care disciplines should work within their professional ethics and technical skills under his direction.

Nursing education should accept and foster the concept that the nurse working with the physician is the logical basic core of the medical team entity and the key to provision of optimum health care. No other group can relace the nurse in this capacity. Nor can the nurse, as a completely independent practitioner, fit into this significant concept.

3. Unquestionably the roles of the nurse in the future will be multifaceted and on multi levels. Nursing education must be geared to produce nurses equipped to the best possible degree to give the finest and most adequate care within each specific sphere. No one system or type of school can encompass the education and training needs to meet these demands in toto.

Undergraduate nursing education, in all levels, should have as its first and basic goal the teaching of primary nursing care of the patient. It is upon such foundation that there must be constructed the advanced training needed to produce the variety and levels of knowledge, skills, and expertise for adequate and satisfactory nursing care in all fields.

Because of the varying levels of nursing skills, backgrounds, and specialties, plus varying capacities and limitations of individuals, all four levels of nursing education must be maintained and constantly improved. These four levels, each of which is needed, are: practical nursing, associate degree, diploma school, and baccalaureate.

The quality of undergraduate nursing education must be maintained by adequate admission requirements for each level of training and by continuing achievement requirements for each in order to attain certificate, diploma, or degree.

4. The trend to lump all nursing education in academia should be slowed down. Basic nursing education requires acquisitions of patient care skills, as well as theoretical background, and the best place to acquire patient care skills is to work with patients in the place where patients are—the hospital, the out-patient clinic, and the doctor's office. There is a proper balance between

theory and practice; and in the training of students for patient care, practice assumes a larger and larger proportion of that balance. While educational institutions must of necessity handle graduate and baccalaureate education, only those in medical centers or with medical center facilities can adequately give the needed clinical experience. Clinical experience has been well taught outside of academia for years and can still be obtained from those sources if even mild support is offered.

5. The tendency to require formal education beyond patient needs and individual nurse or student capabilities must be resisted. Graduate education to prepare for advanced teaching, major administration, and sophisticated research is a must. Baccalaureate education is needed to prepare for routine teaching, most administration, and as a basis for specialty training. Diploma, associate degree, and practical nurse training are needed to prepare for the basic functions of patient care. All types are necessary for balanced and coordinated delivery of such care.

Advancement on the professional career ladder must be available to all nurses. Advancement from practical nurse to associate degree or registered nurse and from associate degree and registered nurse to baccalaureate and higher degree must not only be available but encouraged to the limit of the individual's capability of achievement.

6. Postgraduate education assumes two primary functions—training for specialty careers in nursing and the need to keep abreast of progress and developments in the nursing profession. Specialty training is a function of the medical specialty organization, the nursing specialty organizations, and certain educational institutions. Emphasis must be placed on quality instruction and adequacy to meet the needs of the particular nursing specialty.

Continuing education is a must. Postgraduate courses, conferences, symposia, colloquies, workshops, in-service training, etc., to meet predetermined quantitative hour totals to maintain licensure would be a means to insure that all keep up with advances in the profession, particularly those related to patient care.

Postgraduate education for areas involving the practice of medicine—nurse anesthetists, nurse midwives, nurse practitioners, and physicians' assistants of various types, is purely a function of the medical profession and its educational facilities.

7. Any committee with too large or too diversified a regular membership becomes ineffectual. To reach satisfactory conclusions concerning the training and qualifications of individuals for delivery to our fellow citizens of the finest medical care, the basic committee should be composed of those who constitute the backbone of the health care delivery team—physicians and nurses. Other allied or associated professionals should be invited to participate as consultants at appropriate and indicated times."

For the Waiting Room Wigglers...

For the convenience of physicians who wish to provide waiting room reading material for youngsters, the following list of periodicals has been recommended by the Michigan Library Service and made available through the special library services division of the Pennsylvania State Library:

Animal Kingdom—$4.50—New York Zoological Society, Zoological Park, Bronx, New York 10460.

Children's Digest—$5.95—Parents' Magazine Enterprises, Inc. Bergenfield, New Jersey 07621.

Co-Ed—$2.40—Scholastic Magazines, Inc., 50 West 44th St., New York, N.Y. 10036.

Jack and Jill—$5.95—Curtis Publishing Co., Independence Square, Philadelphia, Pa. 19105.

Kids—$6.00—Kids Publishers, Inc., 77 Third Ave., New York, N.Y. 10017.

Ranger Rick's Nature Magazine—$6.00—National Wildlife Federation, 1412 Sixteenth St., Washington, D.C. 20036.

Teen—$5.00—Petersen Publishing Co., 5959 Hollywood Blvd., Los Angeles, California 90028.

Young World—$6.00—Golden Magazine, 1100 Waterway Blvd., Indianapolis, Indiana 46202.

continuing education

This issue carries no education course listings. Beginning in September, continuing medical education announcements will be published only twice a year in a special continuing medical education supplement to PENNSYLVANIA MEDICINE.

June 15, 1974, is the deadline for receipt of announcements to be printed in September. Mail all data (date, place, sponsor, subject) to:

Pennsylvania Medical Continuing Education Institute
20 Erford Road
Lemoyne, Pennsylvania 17043.

It is important to meet the June deadline, since delay will result in a six month wait until the January edition.

To obtain a copy of the continuing medical education announcements that are recorded at the Institute Office, write to the above address.

cardiovascular brief

Control of heart rate in atrial fibrillation

RICHARD D. GENTZLER II, M.D.
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Hershey

Perhaps the most common error made in the management of chronic atrial fibrillation (AF) is failure to adequately control ventricular rate. While it is generally assumed that AF per se, with loss of atrial contribution to ventricular filling, or the underlying cardiac abnormality is responsible for congestive cardiac symptoms, it is apparent that an excessive rate response to modest effort, with consequent substantial elevation in pulmonary venous pressure and attenuation in cardiac output, contributes importantly to cardiac disability in many patients. In fact, since it can be shown that conversion of the arrhythmia and re-establishment of sinus rhythm results in little or no change in overall cardiac performance in patients with most forms of heart disease, adequate control of heart rate assumes increasing importance in the management of chronic congestive heart failure (CHF) in such patients.

It has now been shown that usual doses of digitalis, digoxin 0.25 mgm or digitoxin 0.1 mgm daily, often fail to control heart rate in AF. Indeed, it appears that substantial, even toxic blood levels of digitalis may be required to control heart rate in many patients. If the heart rate, measured from the apical pulse of electrocardiogram, is not controlled with digoxin 0.25 mgm twice daily, or if excessive rate occurs in the setting of high therapeutic blood levels of this drug, consideration should be given to the addition of small doses of propranolol, beginning with 10 mgm twice daily and progressing to 20 mgm four times daily. Propranolol, by virtue of its B-sympathetic blocking effect, acts directly on the atrioventricular junction to slow conduction, and thus to limit the ventricular response in AF. This drug, of course, must not be added in the setting of florid CHF or when class III congestive symptoms are associated with substantial cardiac enlargement and radiographic evidence of significant pulmonary vascular congestion, because of its tendency to depress myocardial performance. In addition, propranolol must be avoided in patients with asthma, where it may aggravate bronchospasm.

Several factors other than adequate digitalization may contribute to excessive heart rate with effort in patients with AF. First, reduction of blood volume by the use of potent diuretic agents may result in tachycardia and should be suspected in patients in whom fatigue rather than pulmonary congestive symptoms is associated with a rapid ventricular response in AF. Also, quinidine is not infrequently given in association with digitalis in patients with AF, either because of what are thought to be ventricular premature beats or because it is assumed this drug may result in reversion to sinus rhythm. It is important to note that quinidine, through its vagolytic action, tends to accelerate atrioventricular conduction in effect counteracting the indirect vagotonic action of digitalis which slows the ventricular rate. Thus, quinidine actually accelerates the heart rate in AF.

On occasion, especially in patients with chronic obstructive pulmonary disease, AF is diagnosed when actually multifocal atrial tachycardia is present. This dysrhythmia will not slow with digitalis therapy, and its use in increasing dosage may lead to life-threatening ventricular tachyarrhythmias.

Finally, other pathophysiologic states, such as anemia or apathetic thyrotoxicosis, may be present in patients with AF and require appropriate treatment before adequate control of heart rate can be obtained.

This Brief is edited by James H. Gault, M.D., director of the Cardiovascular Laboratories at Lancaster General Hospital for the Pennsylvania Affiliate of the American Heart Association.

Chemical burns

ALBERT M. CALABRETTA
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Accidental contact with chemicals, or their misuse, is one of the potential hazards of our modern life. Chemical burns may produce various superficial and systemic reactions. The effects of various chemicals is determined by (1) the strength or concentration, (2) duration of contact, (3) penetrability, (4) amount, and (5) mechanism of action. The resulting effects include burns, stricture from corrosion, asphyxiation, systemic intoxication, perforation of organs by penetration of the chemical, respiratory irritation, and deleterious reactions in the gastrointestinal and nervous systems, the kidney, liver, and other organs.

Common chemical burns of the skin will be reviewed in this presentation. The pathophysiologic effects of chemical burns must be considered. Chemical burns differ from those from other causes in that the destructive process resulting from a particular chemical continues until the offending agent is either inactivated by chemical combination with the tissues, is neutralized, or is eliminated from the skin surface. In injuries attributable to acids or alkalis, which account for the majority of chemical burns, the common factor responsible for the trauma is the $H+$ or OH- concentrations, respectively. Corrosive injury also involves other factors such as coagulation, precipitation, dehydration, or actual solution of protein. Burns resulting from acids may be extremely destructive, and their effect is immediately apparent.

In contrast, alkali burns are deceptive. Initially their effect may appear slight, but they worsen by direct extension. The mechanism of action of these chemicals produces the different injuries. The acid $H+$ ion destroys upon contact with a surface but is often neutralized immediately. Alkalis, on the other hand, combine with the tissue elements to form alkaline albuminates or with fats to form soaps, often producing an exothermic reaction. Alkali proteinates are soluble, thus permitting passage of the OH- ions more deeply into the tissue before it is inactivated. Furthermore, in alkali burns a latent period may precede the onset of action.

The treatment of chemical burns immediately after the accident is directed toward elimination of the agent by irrigation, dilution, and neutralization. Copious irrigation of the burned areas with water should be done immediately to dilute the chemical agent. Neutralizing a caustic chemical before it has been thoroughly diluted is not justifiable. The heat generated from the neutralization process may in itself be sufficient to cause a thermal injury. Irrigation with water is still the mainstay of chemical burn therapy. It serves the following purposes: (1) dilution of the agent, (2) cleansing of the agent off the skin, (3) restoring normal skin pH, (4) decreasing the tissue metabolism and the inflammatory process, (5) decreasing the rate of the chemical reaction, and (6) minimizing the hygroscopic effects of certain agents.

The value of chemical neutralization is controversial. Some would advocate applying a counter solution to an acid or alkali burn, others would not. The latter group emphasize the danger of the heat of neutralization involved. However, the heat of dilution must be considered in water irrigation and indicates the need for constant flow irrigation. There are a few special cases in which it is advantageous to use the chemical neutralization technique. An outstanding example is hydrofluoric acid burns. While water irrigation is being performed, the area of injury is injected with 10 percent calcium gluconate. The calcium and fluoride ions combine in the neutralization process. Thereby the liquification of cellular membranes and decalcification of bone caused by the fluoride ion is prevented. Other forms of therapy specific for certain types of chemical burns are available.

White phosphorus ignites spontaneously in air when dry. Therefore, in phosphorous burns it is necessary to remove contaminated clothes, irrigate copiously with water, and carefully debride all visible, embedded particles. All removed phosphorous particles should be submerged in water to prevent spontaneous ignition. The burn area should then be briefly rinsed with 1 percent copper sulfate solution. The copper reacts to form copper phosphide, a black precipitate, which makes any retained particles after irrigation and debridement easier to identify and at the same time impedes further oxidation or tissue destruction. The excess copper sulfate should be thoroughly removed through water irrigation to prevent systemic copper toxicity.

Subsequent to the initial dilution, debridement, and fluid resuscitation of chemically injured patients, tetanus prophylaxis, topical antibiotics, and if needed systemic antibiotics should be employed along with biological dressings or autografting as required.

The authors are with the department of surgery, division of plastic surgery, Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. *The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.*

Official Call to the 1974 Annual Session Pennsylvania Medical Society House of Delegates

The 1974 Annual Session of the House of Delegates of the Pennsylvania Medical Society will convene in the Ballroom of the William Penn Hotel, Pittsburgh, Pennsylvania, Thursday, October 10, 1974, at 1 p.m. The second session of the House of Delegates is scheduled for Friday, October 11, in the Ballroom beginning at 1 p.m. The third, and concluding session of the House, will begin Saturday, October 12, 1974, in the Ballroom, beginning at 9 a.m. The Reference Committee on Rules will hold an open hearing at 10 a.m. Thursday, October 10, in the Parlor Rooms, B and C, to consider among other items whether executive secretaries should be seated with delegates.

Elections

Nominations and/or elections will be held at the second session Friday afternoon, October 11, 1974, as called for in Standing Rule No. 1 of the House of Delegates. Among the general officers to be elected by the 1974 House of Delegates will be: a Vice President, a Secretary, a Speaker of the House of Delegates, and a Vice Speaker of the House of Delegates. Society policy calls for a minimum of two candidates to be nominated for Vice Speaker. Also to be elected are a Trustee and Councilor for the First Councilor District, to serve five years to succeed Donald R. Cooper, M.D., Philadelphia County, who is eligible for re-election; a Trustee and Councilor for the Sixth Councilor District, to serve for five years to succeed H. Thompson Dale, M.D., Centre County, who is not eligible for re-election, having served two five-year terms.

Also to be elected for a two-year term beginning January 1, 1975, will be six delegates and six alternates to the American Medical Association. Delegates whose terms expire December 31, 1974, are: Raymond C. Grandon, M.D., Dauphin County; Edmund L. Housel, M.D., Philadelphia County; William A. Limberger, M.D., Chester County; William Y. Rial, M.D., Delaware County; George A. Rowland, M.D., Columbia County; and William B. West, M.D., Huntingdon County.

Alternate Delegates whose terms expire December 31, 1974, are: R. William Alexander, M.D., Berks County; Harry V. Armitage, M.D., Delaware County; Jerome Chamovitz, M.D., Allegheny County; John H. Harris, Jr., M.D., Cumberland County; Richard L. Huber, M.D., Lackawanna County; and R. Robert Tyson, M.D., Philadelphia County.

As directed by Chapter XIV, Section 2(e) of the Bylaws, the Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for delegates for two-year terms commencing January 1, 1975:

1. R. William Alexander, M.D. (Berks County)
2. Raymond C. Grandon, M.D. (Dauphin County)
3. Edmund L. Housel, M.D. (Philadelphia County)
4. William J. Kelly, M.D. (Allegheny County)
5. William Y. Rial, M.D. (Delaware County)
6. George A. Rowland, M.D. (Columbia County)

The Committee makes the following nine nominations for six alternate delegates for two-year terms commencing January 1, 1975:

1. Harry V. Armitage, M.D. (Delaware County)
2. Robert J. Carroll, M.D. (Allegheny County)
3. Kenneth L. Cooper, M.D. (Lycoming County)
4. James B. Donaldson, M.D. (Philadelphia County)
5. Richard L. Huber, M.D. (Lackawanna County)
6. David J. Keck, M.D. (Erie County)
7. Robert Poole III, M.D. (Chester County)
8. John L. Steigerwalt, M.D. (Montgomery County)
9. R. Robert Tyson, M.D. (Philadelphia County)

To fill the unexpired term (December 31, 1975) as an alternate delegate created by the elevation of Dr. Kelly to delegate, the committee nominates Lawrence D. Ellis, M.D., Allegheny County.

Also to be elected will be two members to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. One election is required to fill the position of Donald E. Harrop, M.D., Chester County, whose term expires. This election is to a three-year term. The second election is made necessary by the decision of Edgar W. Meiser, M.D., Lancaster, who wishes to resign from the committee. The House must elect a member to fill the unexpired portion of Dr. Meiser's term, one year. Also to be elected will be one member of the Judicial Council to serve for a term of three years to succeed Lewis T. Buckman, M.D., Luzerne County, who is eligible for re-election.

As directed by Article IX, Section 5 of the Constitution, the Board of Trustees nominates the following members for the vacancy on the Judicial Council: for the office now held by Lewis T. Buckman, M.D., the Board nominates Lewis T. Buckman, M.D., Luzerne County; Edward Lyon, Jr., M.D., Lycoming County; and O.K. Stephenson, M.D., Perry County.

Also to be elected is a District Censor from each component county medical society to serve for one year following the close of the 1974 House of Delegates Session.

The component county medical societies have submitted the following nominations for District Censor:

Adams, **James H. Allison;** Allegheny, **William D. Stewart;** Armstrong, **Arthur R. Wilson;** Beaver, **Herman Bush;** Bedford, **James K. Gordon;** Berks, **Eugene Mendelsohn;** Blair, **John W. Hurst;** Bradford, _____; Bucks, **Stanley F. Peters;** Butler, **Robert C. McCorry;** Cambria, **Warren F. White;** Carbon, _____; Centre, **H. Richard Ishler;** Chester, **Grant W. Bamberger;** Clarion, **Theodore R. Koenig;** Clearfield, **Fred Pease;** Clinton, **George J. Trieres;** Columbia, **James F. Youngkin;** Crawford, **David D. Kirkpatrick, Jr.;** Cumberland, **Hans S. Roe;** Dauphin, **Robert**

P. Dutlinger; Delaware, **Richard W. Garlichs;** Elk-Cameron, **Robert J. Dickinson;** Erie, **Robert L. Loeb;** Fayette, **Harold L. Wilt;** Franklin, **Albert W. Freeman;** Greene, **William W. Bartholomew;** Huntingdon, **Thomas R. Mainzer;** Indiana, **John W. Mills;** Jefferson, **Nicholas F. Lorenzo;** Lackawanna, **Louis J. Vitale;** Lancaster, **William A. Schaeffer;** Lawrence, **Gerald H. Weiner;** Lebanon, **C. Ray Bell;** Lehigh, **William F. Boucher;** Luzerne, **Samuel T. Buckman;** Lycoming, **Franklin G. Wade;** McKean, **Bruno P. Sicher;** Mercer, **Frank E. McElree;** Mifflin-Juniata, **Donald E. Basom;** Monroe, **Claus Jordan;** Montgomery, **Rudolph K. Gloecker;** Montour, **Robert L. Gatski;** Northampton, **Walter J. Filipek;** Northumberland, **J. Mostyn Davis;** Perry, **James Rumbaugh;** Philadelphia, **Charles M. Thompson;** Potter, **Herman C. Mosch;** Schuylkill, **Joseph T. Marconis;** Somerset, **Alexander Solosko;** Susquehanna, **Raymond C. Davis;** Tioga, **Lane H. Webster;** Union, **Joseph Weightman;** Venango, **Jack E. Torin;** Warren, **D. Jack Furman;** Washington, **Joseph N. McMahan;** Wayne-Pike, **Emil T. Niessen;** Westmoreland, **Leslie S. Pierce;** Wyoming, **John S. Rinehimer, Jr;** York, **Donald R. Gross.**

Proposed Amendments to the Constitution and Bylaws

Printed below is the text of the amendments to the Constitution and Bylaws which are being proposed by the Committee on Constitution and Bylaws.*

** Material underlined is being added. Material in brackets is being deleted.*

Subject One

1. Unified membership in county, state and national medical societies.

Constitution

Article IV - Membership

Section 2. Active Members. The Active Members of this Society shall be physicians who are members of the Component Societies and the American Medical Association.

(Secretary's Note: Two-thirds vote required.)

Bylaws

Chapter I - Membership

Section 2. Membership Compulsory. Every member of a Component Society eligible for membership in this Society as provided in Article IV of the Constitution shall become a member of this Society and the American Medical Association within three months after his election to any class of membership therein, unless such member is a provisional or honorary member of the Component Society, in which event he shall not be required to become a member of this Society until three months after his election to some other class of membership.

(Secretary's Note: Three-fourths vote required.)

Subject Two

II. Elimination of delinquent dues requirement.

Bylaws

Chapter IX - Assessments and Funds

Section 2. Delinquent Assessments. A member whose assessment is not paid at the time mentioned in Section 1 above shall be delinquent and shall not be in good standing in this Society. No delinquent member shall be entitled to exercise any of the rights and privileges of membership in this Society during the period of his delinquency. The Executive Vice President shall send a notice to each delinquent member witin sixty days of the date such member becomes delinquent, stating the amount then due and the fact that unless such amount is paid within thirty days after the date thereof the membership of such member will be terminated automatically as provided in Chapter 1 of these Bylaws. [No member of this Society whose membership has been terminated as provided above shall be reinstated until his delinquent assessment has been paid.]

(Secretary's Note: Three-fourths vote required.)

Subject Three

III. Proposals of the Judicial Council for disciplinary proceedings and appeals.

Bylaws

CHAPTER XIII—Disciplinary Proceedings and Appeals

Section 1.—Scope of Disciplinary Proceedings. No disciplinary proceedings shall be conducted by any body of this Society, except (a) a Component Society, (b) original disciplinary proceedings by the Judicial Council as provided in Section 3 of this Chapter, (c) appeals to District Boards of Censors as provided in Section 4 of this Chapter, and (d) appeals to the Judicial Council as provided in Section 5 of this Chapter. Each Component Society shall establish a county board of censors to be responsible for disciplinary proceedings involving members of the Component Society, and shall file a report on disciplinary activities annually with the Secretary of this Society. The grievance committee shall cause a notice to be published at least annually in a newspaper of general circulation in the county setting forth the purposes of the grievance committee and the manner in which persons may contact it. All written and signed communications received by the Secretary of this Society, containing changes against a member which could require disciplinary proceedings, shall be forwarded by the Secretary to the appropriate grievance committee. If the Secretary shall not have received reasonable assurances within forty-five days after receipt of the communication by the grievance committee that the grievance committee has considered the changes, the Secretary may refer a copy of the communication to the county board of censors. If the Secretary shall not have received reasonable assurances within forty-five days after receipt of a copy of the communication by the county board of censors that the county board of censors has considered the charges, the Secretary may refer a copy of the communication to the District Board of Censors, which may initiate original disciplinary proceedings.

Section 8.—Notification of Expulsion. Written notification of all final decisions expelling a member for disciplinary reasons shall be given to the State Board of Medical Education and Licensure and the appropriate hospital medical staff.

House adopted in Principle:

Section 9. - Automatic Suspension. Any member of this Society convicted by a court of competent jurisdiction of the commission of a felony or any crime involving moral turpitude, which term for the purposes of this chapter shall include any violation of the federal tax laws or laws relating to health care, shall be automatically suspended for an indefinite period. It shall be the duty of the Secretary promptly to inform the appropriate county board of censors of any such conviction of any member of this Society, however, any member of the Society having any such information should promptly report the same to the county board of censors. The county board of censors shall make due inquiry and if it finds that such member has, in fact, been so convicted, it shall order a certified copy of the conviction from the court and upon receipt thereof it shall be filed with the member's records. The county board of censors shall thereupon notify the member that he will stand suspended from membership for an indefinite period, beginning ninety days following his conviction by the court, or ten days following the notice if such notice is issued more than ninety days after the conviction, unless prior to the effective date of the suspension, the member certifies to the county board of censors that he has filed an appeal from the conviction. If the member so convicted has so appealed, the suspension from membership shall be stayed until such time as the appeal has been finally disposed of by a court of last resort, and such suspension shall be completely nullified in the event that the conviction of the member is reversed by such court.

Section 10.—Reinstatement after suspension. Any member indefinitely suspended from membership pursuant to the provisions of Section 9 of this chapter may be reinstated to full membership after a period of six months from the effective date of the suspension. Applications for reinstatement may be submitted not earlier than four months after the effective date of the suspension, shall be in writing setting forth the reasons why the member believes he is entitled to reinstatement, and shall be filed with the county board of censors. The county board of censors, after due inquiry, shall hold a meeting to consider the application. The suspended member shall be reinstated upon a majority vote of the members of the county board of censors present and voting at the meeting, provided that there is a quorum of at least four members present at the meeting.

The following amendment for disciplinary proceedings is offered by the Committee on Constitution and Bylaws as an alternative to the above Sections 9 and 10.

Section 9. The Secretary of this Society shall immediately notify the appropriate county board of censors of conviction of a member of this Society by a court of competent jurisdiction of the commission of a felony or any crime involving moral turpitude, which term shall include any violation of the federal tax laws or laws relating to health care.

(Secretary's Note: Three-fourths vote required.)

Bylaws

CHAPTER XVI—Component Societies

Section 3.—Investigation of Applicants for Membership. Remembering that the Component Society is the only portal to this Society and to the American Medical Association, each Component Society shall make a thorough investigation of initial and transfer applicants for membership therein, including a formal inquiry to the Biographic Department of the American Medical Association; this Society; the State Board of Medical Education and Licensure; and the Credentials Committee of each hospital where the applicant holds, or most recently held, privileges; so that only reputable physicians, licensed to practice their profession in Pennsylvania, and only bonafide interns and residents may be admitted to active membership in the Component Society. Certification of completion of such investigative processes shall be certified to this Society by the chairman of the county board of censors.

(Secretary's Note: Three-fourths vote required.)

Subject Four

IV. Elimination of Delegate Registration Cards

Bylaws

CHAPTER III—House of Delegates

Section 4. - Credentials of Delegates. Prior to the opening of any session of the House of Delegates, [each voting delegate and each alternate delegate shall deposit with the Committee on Credentials a certificate signed by the President and/or] the Secretary of [the] each Component Society, under the seal of the same, [stating that he has been] shall certify to this Society the names of each voting delegate and each alternate who has been legally and regularly designated as a voting delegate or alternate delegate to this Society. [Specialty section delegates and alternates shall deposit with the Committee on Credentials a certificate signed by the President and/or the] the Secretary of [their respective] each specialty society in Pennsylvania [stating that said persons] shall certify to this Society the names of the voting delegate and the alternate who have been legally and regularly designated as that society's voting delegate and alternate to this Society's House of Delegates. Each Special Student Member of his alternate shall deposit with the Committee on Credentials a certificate signed by the Secretary of this Society under the Society's seal which states that he is the duly certified representative of his Chapter of the Student American Medical Association. No voting delegate and no alternate delegate may be seated until the foregoing requirement has been complied with, provided, however, that the Credentials Committee may waive this requirement in unusual cases when satisfied that the person presenting himself as a voting delegate or alternate delegate is the person who has been certified as such to the executive Vice President in accordance with the provisions of Article VI of the Constitution, or has been duly selected in accordance with Section 3 of Article VI of the Constitution of this Society. Prior to the opening of any session of the House of Delegates, the Executive Vice President shall certify to the

Committee on Credentials the names of all members of the House of Delegates as shown on his official records. Such certification shall be sufficient for the seating of the secretaries or presidents of Component Societies and for the identification of the voting and non-voting members of the House of Delegates. Any dispute that shall arise as to the seating of any voting delegate or any alternate delegate shall be determined by the House of Delegates after a report thereon by the Committee on Credentials, and the action of the House in such cases shall be final.

(Secretary's Note: Three-fourths vote required.)

Subject Five

V. Allowance for the Past Speaker of the House to speak from the floor.

Constitution

Article VI - House of Delegates

Section 2. Composition - The House of Delegates shall be composed of (a) delegates (or their alternates) elected by the Component Societies in the proportion of one delegate for every one hundred or fraction thereof of its Active, Senior Active, Intern and Resident Members in this Society whose dues are paid or excused as of December 31 of each preceding year, whose term of office shall be for a term of one year or for a term in excess of one year if such Component Society's Bylaws provide for a longer term than one year provided that at least one delegate or alternate be elected by such Component Society each year, and whose names have been submitted to the office of the Executive Vice President of the Pennsylvania Medical Society as instructed by the Executive Vice President, and in January of each year the Executive Vice President of the Pennsylvania Medical Society shall certify to each Component Society the number of delegates to which it is entitled during the current year; (b) the secretaries of the Component Societies in office at the time of any meeting of the House of Delegates; (c) specialty section members, delegates elected by the American Medical Association Board certified specialties having organized societies in Pennsylvania on the basis of one delegate for each such specialty society, such specialty delegates shall be Active, Senior Active, Intern, or Resident Members in good standing in this Society; (d) special student members (or their alternates) as defined in Sections 9 and 10 of Article IV; and (e) ex officio, but without the right to vote, the Speaker [and], Vice Speaker, and Immediate Past Speaker, of the House of Delegates, the President, President Elect, the Vice President, the Secretary, the Trustees and Councilors, and the members of the Judicial Council of this Society, the ex-presidents of this Society and the presidents of the Component Societies, except that any of the foregoing ex officio delegates, other than those prohibited from so doing by Article V of this Constitution, may at the same time serve as voting delegates duly designated as such by the respective Component Societies, and except that the Speaker, or the Vice Speaker when serving as Speaker, shall have the right to vote in all cases where his vote would change the result of a vote taken other than a vote decided by ballot.

(Secretary's Note: Two-thirds vote required.)

Subject Six

VI. Alternates to Reference Committees

Bylaws

Chapter III - House of Delegates

Section 9. Reference Committees. The Reference Committees of the House of Delegates shall consist of five members, and such alternates as the Speaker of the House of Delegates may deem necessary, whose terms shall end the following May 31, appointed annually by the Speaker of the House of Delegates prior to August 1 from among the then certified voting delegates. The Speaker shall appoint such Reference Committees and clearly identify them as he deems necessary to expedite the business of the House.

In addition to the foregoing, the standing Committee on Constitution and Bylaws shall be a Reference Committee of the House of Delegates during the annual meeting of the House of Delegates. Each member of this Society has the right to appear and be heard before any reference committee of the House of Delegates.

Each report, resolution and proposition presented to the House of Delegates shall be referred for consideration and report to one or more of the Reference Committees, as may be appropriate and as the Speaker of the House of Delegates shall determine. The reports of the Reference Committees shall be presented to the House of Delegates before final action may be taken unless otherwise ordered by the House of Delegates by a two-third vote of those present and voting.

(Secretary's Note: Three-fourths vote required.)

Subject Seven

VII. An amendment proposed by the Committee on Constitution and Bylaws to codify the Society's policy that at least two candidates be presented for the office of Vice Speaker.

Bylaws

Chapter IV—Elections

Section 5.—Nominations. All candidates for any office to be elected by the House of Delegates, including at least two nominees for the office of Vice Speaker, may be nominated from the floor except that candidates for the Board of Trustees and Councilors shall be nominated only by a delegate from the nominee's Councilor District. No nomination shall be accepted by the House unless the delegate moving the nomination states that the nominee meets all of the qualifications prescribed by the Constitution and Bylaws for the office. In addition to nominations from the floor, (a) candidates for delegates and alternates to the American Medical Association may and should be nominated by the Committee provided for in Section 2(e) of Chapter XIV of these Bylaws, (b) a candidate for District Censor may and should be nominated by each Component Society, and (c) candidates for the Judicial Council may and should be nominated by the Board of Trustees and Councilors.

(Secretary's Note: Three-fourths vote required.)

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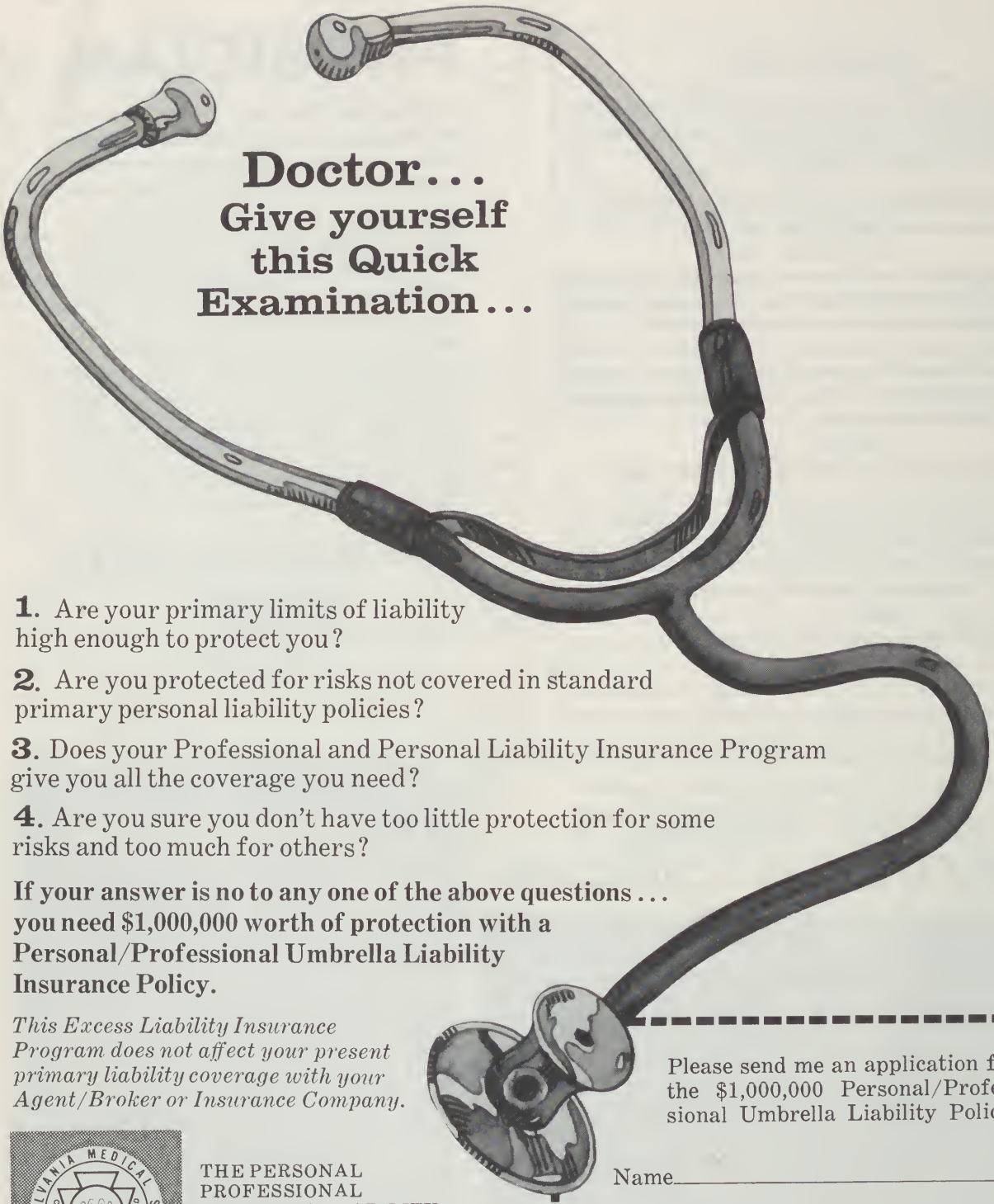

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Paul E. Almeida,** Media; University of Brazil Medical School, 1948; age 50; died April 19, 1974. He was a pathologist at Crozer-Chester Medical Center and a member of the College of American Pathologists. He is survived by his wife, his mother, a daughter, two sons, and a sister.

• **Joseph T. Boylan,** Scranton; Georgetown University School of Medicine, 1936; age 62; died April 26, 1974. He is survived by his wife, two daughters, four sons, a sister, and a brother.

• **Alfred E. Brunswick,** Philadelphia; Jefferson Medical College, 1925; age 72; died February 14, 1974. No information is available regarding survivors.

• **William V. Coyle,** Hazleton; Jefferson Medical College, 1917; age 86; died April 5, 1974. He was a consultant to the Hazleton State General Hospital and company ophthalmologist for the Lehigh Valley Railroad. He was a member of the American Association of Railway Surgeons and the Pennsylvania Academy of Ophthalmology and Otolaryngology. He is survived by two sons, John J. Coyle, M.D., Hazleton, and William A. Coyle, M.D., Chester; a sister, and a brother.

• **Andre DeBakker,** Altoona; University of Leiden Medical School, Holland, 1954; age 46; died April 20, 1974. He was director of the anesthesiology department at Altoona Hospital. He was a diplomate of the American Board of Anesthesiology, a fellow of the American College of Anesthesiology, and a fellow of the American College of Chest Physicians. Survivors include his wife, two daughters, a son, a sister, a brother, and his mother.

• **George G. Ebandjieff,** Nanty Glo; Washington University School of Medicine, St. Louis, Missouri, 1925; age 73; died April 25, 1974. He had practiced for over forty-seven years in the Blacklick Valley area where he founded a clinic. He is survived by his wife, a daughter, two sisters, and a brother.

• **Bernard D. Eaton,** Reading; University of Mainz, Mainz, Germany, 1958; age 48; died March 9, 1974. He was medical director of Berks County and at Berks Heim. He was also Berks County deputy coroner. Survivors include his wife, a daughter, and a son.

• **Richard T. Ellison,** Philadelphia; University of Pennsylvania School of Medicine, 1918; age 80; died May 10, 1974. He was a former medical director of All Saints Hospital and was chief of the state chest clinic at Abington Memorial Hospital for thirty-three years. He was a member of the American College of Physicians. Surviving are his wife; a daughter; a son, Richard T. Ellison, Jr., M.D., Abington; and a stepdaughter.

• **Martin J. Fisher,** Yeadon; Hahnemann Medical College and Hospital, 1935; age 64; died April 9, 1974. No further information is available.

George V. Foster, Pittsburgh; University of Toronto School of Medicine, 1923; age 75; died April 5, 1974. He was former chief of surgery at West Penn Hospital, Pittsburgh, and associate professor of surgery at the University of Pittsburgh School of Medicine. He was a fellow of the American Board of Surgeons and a diplomate of the American Board of Surgery. Information on survivors is not available.

• **Clinton A. Hays,** Oil City; Long Island College of Medicine, 1935; age 64; died March 26, 1974. He was a fellow in the American College of Surgeons and the American Society of Abdominal Surgeons. He was a diplomate of the American Board of Abdominal Surgeons and was certified by the American Board of Abdominal Surgery. His wife, two daughters, and a sister survive him.

• **Robert D. Hieber,** Pittsburgh; University of Pittsburgh School of Medicine, 1955; age 53; died April 24, 1974. He was chief of medical service at the Butler Veterans Administration Hospital. He was a member of the International Society of Hematologists, the American College of Physicians, and the Society of Nuclear Medicine. His wife and a daughter survive him.

• **Charles T. Hunter,** Newtown; Harvard University Medical School, Boston, Mass., 1924; age 76; died October 11, 1973. He was a diplomate of the National Board of Medical Education. He is survived by his wife.

• **Henry D. Lafferty,** Oxford, Md.; Hahnemann Medical College, 1929; age 71; died March 28, 1973. Prior to his retirement in 1968, he was clinical professor of obstetrics and gynecology at Hahnemann Medical College and Hospital. He was a fellow of the American College of Surgeons and a diplomate of the National Board of Obstetrics and Gynecology. Dr. Lafferty was one of the founders and the first president of West Park Hospital. He is survived by his wife, three daughters, and two sisters.

• **Jack Lipshutz,** Philadelphia; University of Pennsylvania School of Medicine, 1937; age 63; died March 5, 1974. He had practiced medicine in Wissinoming for thirty-five years, and he was a member of the staffs of Albert Einstein Medical Center, Northern Division, Frankford, and Northeastern Hospitals. He is survived by his wife, two daughters, two sisters, and two brothers.

• **Walter J. McGuigan,** Wilkes-Barre; Georgetown University School of Medicine, 1936; age 63; died March 19, 1974. He was a life member of the American College of Surgeons, a founding fellow of the American Geriatrics Society, and a diplomate of the National Board of Medical Examiners. Survivors include a daughter, a son, and three brothers.

• **Earle L. Mortimer,** Petrolia; University of Pennsylvania School of Medicine, 1920; age 77; died April 28, 1974. He had practiced in his community for over fifty-two years and was on the staff of the Butler County memorial Hospital. Dr. Mortimer was a member of the American Academy of Family Physicians. His wife and a daughter survive him.

(Continued on next page)

• **Frank H. Murray,** Swarthmore; Hahnemann Medical College of Chicago, 1915; age 85; died March 28, 1974. He is survived by his wife and a son.

• **William Pearlman,** Wilkes-Barre; St. Andrews School of Medicine, Scotland, 1934; age 64; died April 21, 1974. He was a past president of the Luzerne County Medical Society and a member of the American Diabetes Association. He is survived by his wife, his mother, a son, a sister, and a brother.

• **Mark L. Redding, Jr.,** Hanover; Georgetown University School of Medicine, 1957; age 41; died March 24, 1974. He was in private practice and was York County deputy coroner. He is survived by his wife; his parents; two daughters; two sons; a sister; and three brothers, two of whom are physicians: Gorman J. Redding, M.D., and Richard J. Redding, M.D., both of Alexandria, Virginia.

• **Taras H. Rybachok,** Chattanooga, Tenn.; Temple University School of Medicine, 1941; age 57; died April 9, 1974. He had practiced in Philadelphia for twenty-years before moving to Chattanooga, where he became industrial physician with the Du Pont Company. His wife, two daughters, a sister, and a brother survive him.

• **Melvin L. Schwartz,** McKeesport; Jefferson Medical College, 1948; age 52; died March 15, 1974. He was a professor of psychiatry at the University of Pittsburgh Medical School and was a fellow of the American Psychiatric Association. Survivors include a sister and two brothers, one of whom is Norman A. Schwartz, M.D., McKeesport.

• **Warren B. Shepard, Jr.,** Pittsburgh; Hahnemann Medical College, 1935; age 63; died April 29, 1974. He was a founding member of the American College of Obstetricians and Gynecologists and was certified by the American Board of Obstetrics and Gynecology. He is survived by his wife and two daughters.

• **Joseph A. Soffel,** Pittsburgh; University of Pittsburgh School of Medicine, 1924; age 71; died March 15, 1974. He was formerly an instructor in surgery at the University of Pittsburgh School of Medicine and had practiced at Shadyside for more than fifty years. He was a member of the American College of Surgeons. Survivors include his wife, two daughters, and a son.

• **John M. Stack,** Wyncote; Jefferson Medical College, 1939; age 61; died April 26, 1974. He is survived by his wife; four sons, one of whom is John M. Stack, Jr., M.D., Philadelphia; his father, five sisters, and a brother.

• **Donald D. Stoner,** Carlisle; Jefferson Medical College, 1931; age 70; died March 2, 1974. Dr. Stoner was certified by the American Board of Otolaryngology, and he was a fellow of the American College of Surgeons, the American Academy of Ophthalmology and Otolaryngology, and the Pennsylvania Academy of Ophthalmology and Otolaryngology. He is survived by his wife, his mother, two daughters, a son and a brother, Robert R. Stoner, M.D., Harrisburg.

• **George E. Thomassy, Jr.,** Hanover; University of Pittsburgh School of Medicine, 1937; age 61; died April 23, 1974. He is survived by his wife, a daughter, four sons, three sisters, and his mother.

• **Henry Walter, Jr.,** Lititz; Jefferson Medical College, 1933; age 64; died March 2, 1974. He was formerly an assistant instructor in gastroenterology at the University of Pennsylvania School of Medicine, a past president of the Lancaster County Medical Society, and served as a consultant in internal medicine at the Masonic Home in Elizabethtown. Dr. Walter was a fellow of the American College of Physicians. He is survived by his wife, a daughter, and a son.

• **John Watchko,** Indiana; Jefferson Medical College, 1937; age 62; died April 4, 1974. He was a diplomate of the American Board of Pediatrics and the American Academy of Pediatrics. He is survived by his wife, a daughter, and two sons.

• **Joseph J. Wunsch,** Lebanon; George Washington University School of Medicine, 1937; age 62; died April 3, 1974. He had retired as Regional Medical director of Pennsylvania five years ago. He is survived by his wife, two daughters, two sisters, and a brother.

• **Charles L. Youngman,** Williamsport; University of Pennsylvania School of Medicine, 1925; age 73; died March 3, 1974. Dr. Youngman was a former trustee of the Pennsylvania Medical Society. Prior to his retirement, he was chief of surgery at both Williamsport and Divine Providence Hospitals. He was a past president of the Lycoming County Medical Society. After retirement, he served as utilization coordinator of the Williamport Hospital and as head physician at Lysock View. He also served as president of the Lycoming County Crippled Children's Society and as a member of the board. Survivors include, a son, a sister, and a brother.

• **Albert R. Zavatsky,** Camp Hill; Hahnemann Medical College, 1951; age 51; died March 1, 1974. He was a member of the American College of Surgeons, the American Academy of Ophthalmology and Otolaryngology, and the American College of Emergency Physicians. Survivors include two daughters, a son, two sisters, and three brothers.

• **Jay D. Zulick,** Kennett Square; Medico-Chirurgical Medical School, 1909; age 90; died October 4, 1973. He was certified by the American Board of Radiology, a past president of the Philadelphia Roentgen Ray Society, a member of the American Roentgen Ray Society and the Philadelphia College of Physicians. He is survived by his wife.

George R. Carpenter, Harrisburg; University of Virginia Medical College, 1934; age 68; died March 26, 1974. Retired from the U.S. Army Medical Corps, he became deputy secretary of health for the Pennsylvania Department of Health. He is survived by his wife, a daughter, a sister, and a brother.

Francis H. O'Neill, Pittsburgh; University of Pittsburgh School of Medicine, 1936; age 63; died March 12, 1974. He was a member of the American College of Chest Physicians. He is survived by his wife, a daughter, three sons, and a brother.

Egon Stricher, Philadelphia; University of Wein Medical School, Austria; age 79; died November 16, 1973. No further information is available.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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up to 100 mg daily in severe anxiety

(chlordiazepoxide HCl)

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Symptom of excessive anxiety:

The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician-patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

for relief of excessive anxiety

Librium® 10-mg capsules
(chlordiazepoxide HCl)

ROCHE

Please see reverse side for summary of product information.

pennsylvania medicine

August 1974

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pennsylvania medicine

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medigram

August 1974

NEW MEDICAL PRACTICE ACT SIGNED Just prior to summer recess, the House of Representatives concurred in Senate placed amendments to House Bills 759 and 760, the Society-supported measures which restructure the State Board of Medical Education and Licensure and redefine its powers and duties. Governor Milton J. Shapp signed the bills into law July 22. In the new law, the State Board remains in the Bureau of Professional and Occupational Affairs and is composed of nine members: The secretary of health, the commissioner of professional and occupational affairs, and seven members appointed by the governor. Of these, five are to be physicians who may be chosen from a list submitted by the State Society; one a person knowledgeable in allied health services; and one a representative of the public at large. The September issue of PENNSYLVANIA MEDICINE will carry an analysis of the law.

PEER REVIEWERS AND DATA NOW PROTECTED Governor Shapp also signed H.B. 1729, Society-supported legislation to protect physicians serving on review committees or those testifying before review committees from liability. The bill also protects the records and data used by review committees, as follows: "The proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a health care professional arising out of the matters which are the subject of evaluation and review by such committee, and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee. . ."

SOCIETY SUPPORTS ARGONAUT FILING Argonaut Insurance Co., underwriter of the Society-sponsored professional liability insurance program, has the support of the State Society in its filing for a rate increase with the Pennsylvania Department of Insurance. The filing, which represents the first rate increase request since the program's inception three years ago, will affect 3,500 Society members who are covered by the program. In a letter to Insurance Commissioner William J. Sheppard, Cyrus B. Sleasę, chairman of the Society's Board of Trustees, said the Society "supports in good faith a rate filing by Argonaut which would generate a statewide overall increase of 50 percent over the rates now in effect." The proposed increase will be borne by all insureds with the greatest percentage applied to those practicing in high risk specialties in high risk areas.

COOPERATIVE CHARTER MEMBERSHIP DEADLINE SET Deadline for charter membership in the Pennsylvania Medical Cooperative is September 30, Robert N. Moyers, M.D., chairman of the Council on Public Service, has announced. A one-time membership fee of $100 would permit participating Society members to enjoy a 30 to 50 percent savings on the purchase of office medical supplies. Page three of this issue explains the cooperative and provides a business reply card for those who wish to join. All membership fees

will be returned if the cooperative fails to reach its goal of 2,000 members, the number necessary to provide start-up funds.

WHO CAN PERFORM ACUPUNCTURE? Attorney General Israel Packel, in an opinion requested by Louis P. Vitti, commissioner of the Bureau of Professional and Occupational Affairs, has said that only doctors of medicine and osteopathic medicine are permitted by the licensing laws to perform unlimited acupuncture. Podiatrists, veterinarians, and dentists would have limited rights to use the procedure. Chiropractors and optometrists are prohibited from using acupuncture by the language of their licensing laws. The AMA and the State Society have issued statements that the use of acupuncture should be limited to physicians and that it must be treated as an experimental procedure.

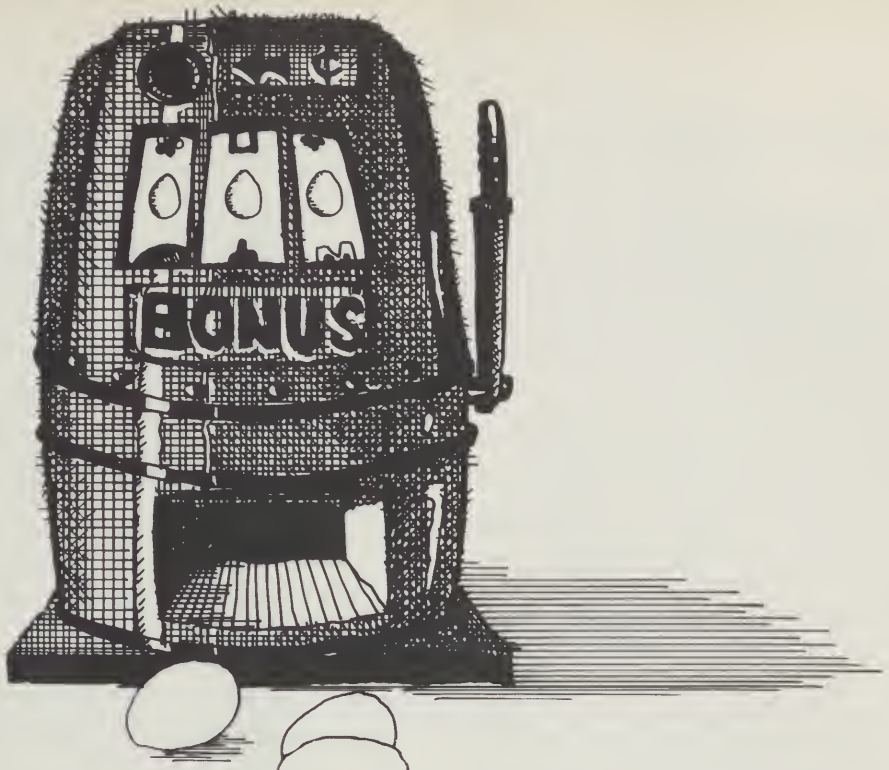
BLUE SHIELD SURVEYS PHYSICIANS Pennsylvania Blue Shield is conducting a physician survey, asking some 3,000 physicians to evaluate Blue Shield performance in such areas as claims payment, allowances, handling of inquiries, and communications. A survey of subscribers conducted last winter reveals satisfaction among subscribers, according to recently released initial findings. Some 6,000 subscribers were contacted, and 40 percent responded.

FOUNDATION MAILS MANUAL The Pennsylvania Medical Care Foundation mailed late in July to presidents of hospital medical staffs a procedural manual for its concurrent utilization review system, the Certified Hospital Admissions Monitoring Program. The manual has been designed to meet both current and proposed medicare and medicaid utilization review requirements -- it will serve as a basis for developing a Professional Standards Review Organization (PSRO) as mandated by federal law, and it will act as an alternative to the Predischarge Utilization Review (PDUR) of the Department of Public Welfare. PDUR or a DPW-approved alternate such as CHAMP, will be mandatory for all hospitals October 1, 1974, DPW Secretary Helene Wohlgemuth is expected to announce shortly.

DR. MASLAND PRESENTS POSITION The Society's position paper, "Health Care in Pennsylvania -- 1974" (see page 30) was presented to the Republican Platform Committee July 30 by David S. Masland, M.D., vice president.

FINAL REGULATION ON COUGH SUPPRESSANTS PUBLISHED The Pennsylvania Department of Health placed narcotic containing cough suppressants on Schedule IV of controlled substances effective July 20. The products will require a physician's prescription, which can be refilled five times within six months following the date on the prescription. The action was taken on recommendation of the Drug, Device, and Cosmetic Board which found the substances have a potential for abuse.

PHYSICIANS AFFECTED BY NEW RULES New drug control regulations promulgated by the Department of Health effective July 6 contain detailed requirements for the manufacture, distribution, prescription, and dispensing of drugs, devices, and cosmetics. Copies of the regulations first proposed over a year ago are available from the department and will be the subject of an article in the September issue of PENNSYLVANIA MEDICINE.



There's no gamble on this investment

Pennsylvania physicians are responding enthusiastically to the proposed formation of a Pennsylvania Medical Cooperative. They feel the Cooperative's cheaper-by-the-dozen approach to the purchase of medical supplies makes a lot of sense. They also appreciate the fact that they are not being asked to take any financial risk whatever in availing themselves of the Cooperative's benefits.

The idea behind the Pennsylvania Medical Cooperative is a very simple and practical one—and one that is especially appealing in these days of rapidly rising costs. What it means is that instead of purchasing supplies in small quantities, individually, the State's physicians will be banding together to make their purchases on a mass basis, in large volume, at significant savings.

Membership in the Pennsylvania Medical Cooperative will be open to Pennsylvania Medical Society members only, through the once-and-done purchase of a modest $100 lifetime share. If the proposed Cooperative should not materialize, the $100 membership fee will be returned in full.

And even after the Cooperative is in operation if you should wish to withdraw all or a substantial part of the membership fee will be returned.

At the outset the Pennsylvania Medical Cooperative will limit itself to the purchase and sale of expendable supplies. By purchasing such supplies in large quantities directly from the manufacturer and reselling them at cost, it is expected that the Cooperative will be able to offer its physician members savings of 30 to 50 per cent. Later, when the Cooperative expands into the field of surgical supplies, office equipment and so on, the potential for savings will be even greater.

The Pennsylvania Medical Cooperative has much to recommend it: an opportunity for substantial savings without any risk whatever, and a chance to simplify your purchasing procedures and take a giant stride toward inventory control. For further information, please write or call.

Pennsylvania MEDICAL Cooperative

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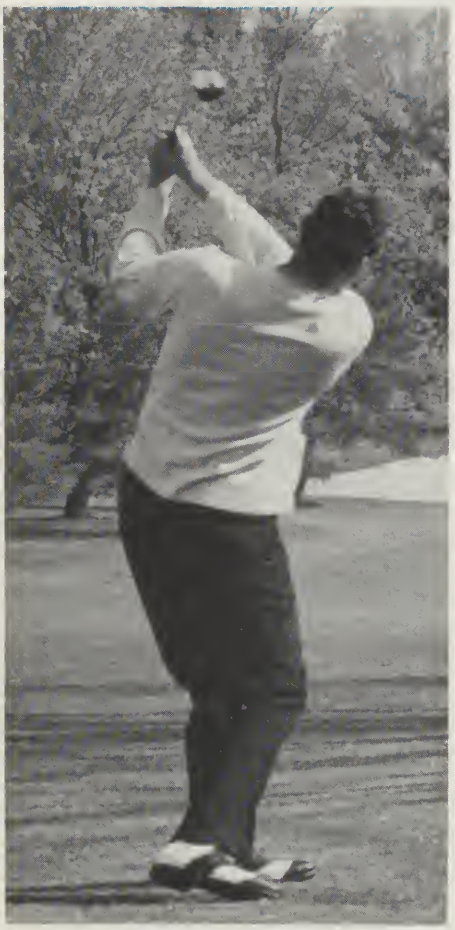
Another New Benefit to Members of Pennsylvania Medical Society

NINETEENTH ANNUAL PMGA TOURNAMENT



September 27, 1974

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Includes: Buffet Luncheon • Hors D'oeuvres • Cocktails • Dinner • Greens Fees • Cart—Caddy • Door Prizes •

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McKee Cup—Blue Shield Handicap—Blue Shield Senior Trophies—Flight Prizes

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Limit to 120 golfers
Entry Deadline September 3

$85 Entry Fee
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Name _____

Address _____ Zip _____

Certified Handicap _____

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Prefer cart _____ caddy _____

Other members of foursome (Not necessary to submit foursome—single entries are acceptable)

1. _____
2. _____
3. _____

Make check payable ($85.00) to: Pennsylvania Medical Golfing Association
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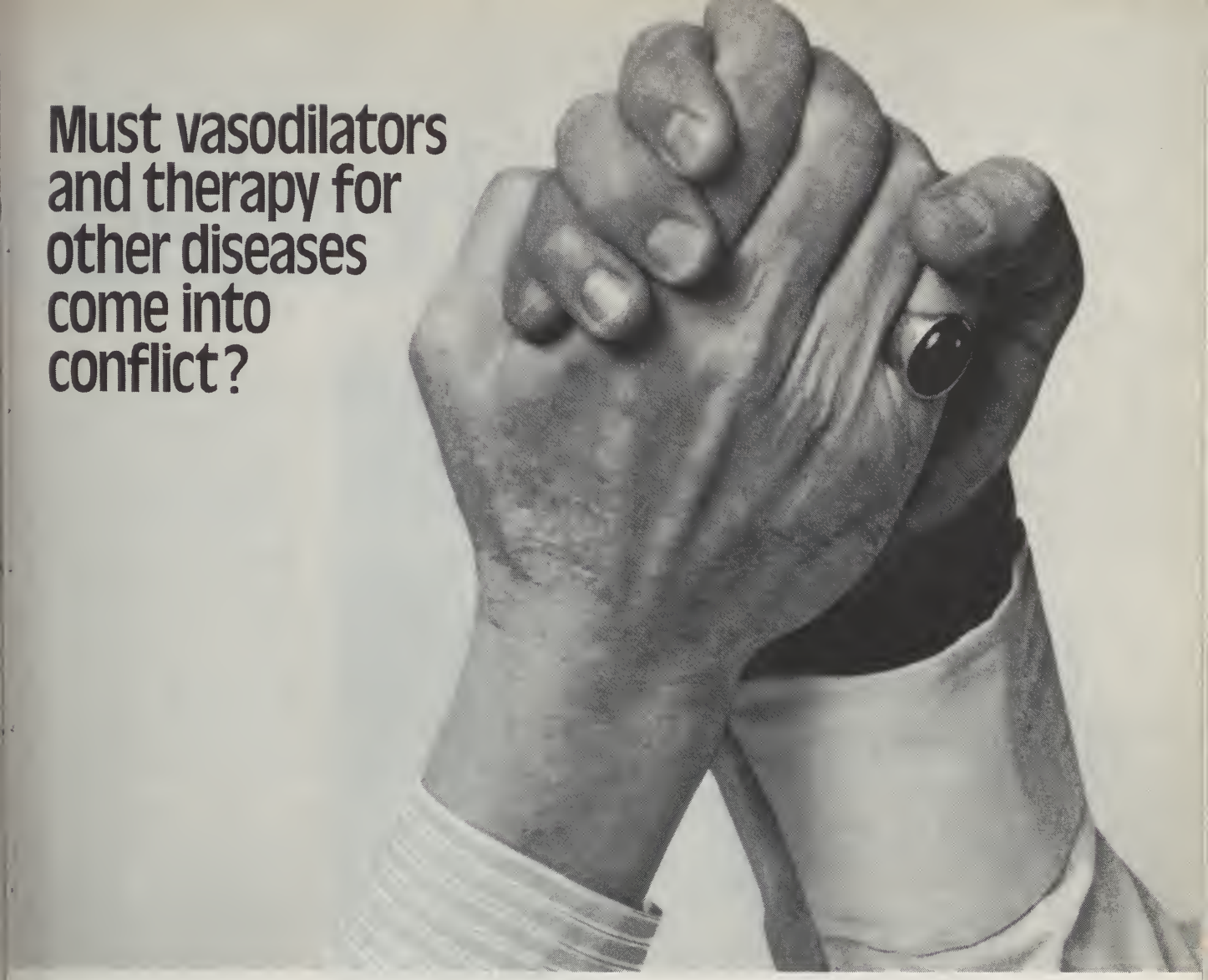
Lemoyne, Pa. 17043

No fee refund after September 3

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

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sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
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For additional product information see your Upjohn representative or consult the package insert.

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MED B-5-S (MBR-1)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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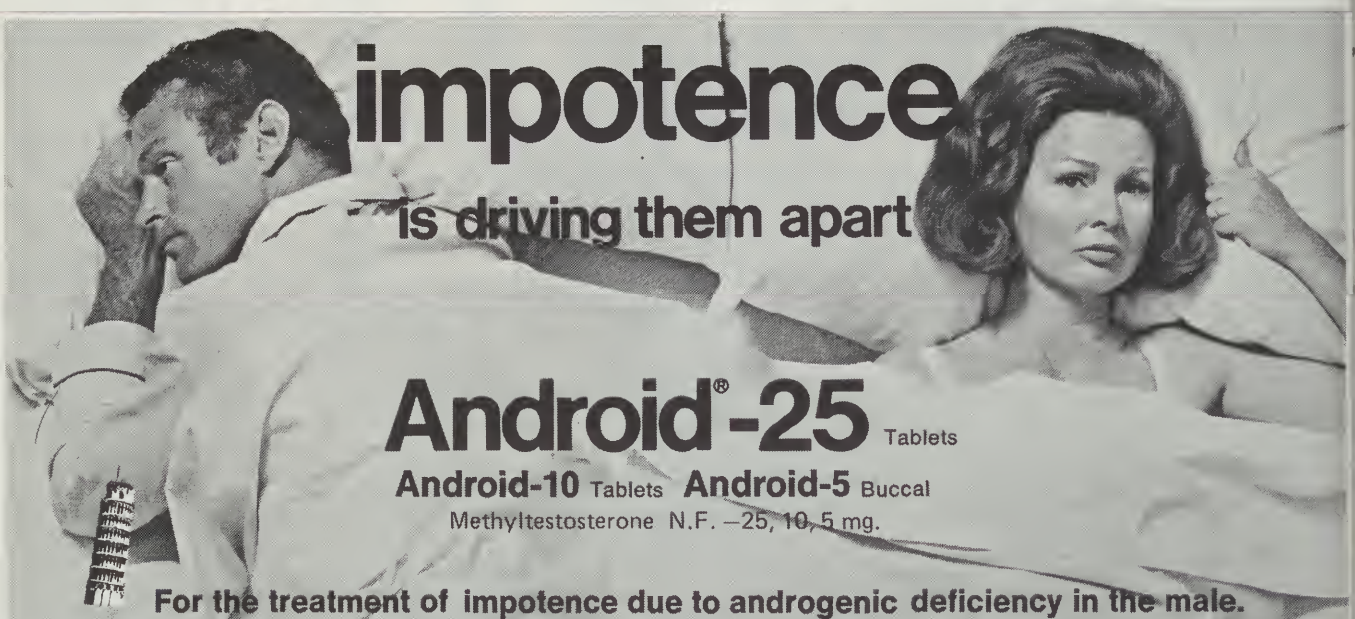

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B--B

Ralph C. Wilde, M.D., Society president, leukemia victim

Ralph C. Wilde, M. D., of Pittsburgh, 124th president of the Pennsylvania Medical Society, died of leukemia July 10, 1974, at the age of 51. Until two weeks before his death he remained active and fulfilled the duties of the office of the presidency.

Dr. Wilde was elected president elect of the State Society at the 1972 Annual Session of the House of Delegates and was installed as president in October 1973. He had been president of the Allegheny County Medical Society and had served the State Society as a member of the Council on Public Service.

He was head of the division of surgery at the Allegheny General Hospital, a member of the staff of Presbyterian University Hospital, the associate staff of Children's Hospital of Pittsburgh, and the consulting staff of the Eye and Ear Hospital of Pittsburgh.

In stating his goals as Society president before the House of Delegates last October, Dr. Wilde gave top priority to tackling and solving the problem of caring for indigent patients instead of talking about it. He said: "We want to be able to provide quality care to all patients, and if it takes more money than is now available to care for the indigent population, then that money must be made available through medical assistance. Right now care for the poor is bogged down in a morass of inaction. We must work toward ending that situation. Some progress toward this end has been made in an improved Department of Public Welfare fee schedule and in providing some outpatient care under medical assistance. This proves it can be done, but we have a long way to go. Whether patient care is delivered in a downtown office or an outpatient clinic, whether it is paid for by the patient's personal check or by the Commonwealth, the care must be of the highest quality and must be comprehensive."

DR. WILDE

Dr. Wilde was enthusiastic about recruiting intern and resident members and having them participate actively in county medical societies, the State Society, and the AMA. During his presidency, the Allegheny County Medical Society made great strides in interesting house staff members in the county society, and a number of them have taken leadership roles in society activities. Since he had a significant responsibility in the residency training program at Allegheny General Hospital, Dr. Wilde was especially interested in spreading the word of the success of the Allegheny campaign. "Now that the AMA has an Interns and Residents Section, I would like to see it represent house staff in relations with hospitals rather than suffer the fragmentation which results when another organization is established for that purpose," he declared.

Dr. Wilde is survived by his wife, Bette; two daughters, Debbie and Diane; his parents; and two brothers.

Memorial contributions may be made to the Western Pennsylvania Chapter, Leukemia Society of America, 907 Empire Building, 507 Liberty Avenue, Pittsburgh, Pa. 15222.

A. Reynolds Crane, M.D., new leader

A. Reynolds Crane, M.D., of Philadelphia, the State Society's president elect since last October, has assumed the duties of the presidency, in accordance with the Constitution and Bylaws.

Dr. Crane, 66, was until June 30 director of the Ayer Clinical Laboratory at Pennsylvania Hospital and pathologist to the hospital's Benjamin Franklin Clinic. He remains as consultant to the laboratory and will continue as professor of pathology at the University of Pennsylvania School of Medicine.

His elevation to the office of presidency of the State Society is the latest of a long list of leadership accomplishments in medicine. He served as president of the Philadelphia County Medical Society, as a member of the State Society's Board of Trustees from 1963 to 1972, and as vice president of the State Society immediately prior to moving up to the post of president elect.

He is a founding fellow of the College of American Pathologists and was a member of its Board of Governors for six years. He also served as president of the Pennsylvania Pathological Society and the Pennsylvania Association of Clinical Pathologists.

Dr. Crane is a diplomate of the National Board of Medical Examiners and is certified by the American Board of Pathology in Pathologic Anatomy and Clinical Pathology. He earned his A.B. degree at Hamilton College, Clinton, N.Y., and his medical degree at Cornell University College of Medicine.

Argonaut's loss prevention program is education

ELI P. BERNZWEIG, J.D.
Menlo Park, California

In January 1974, Argonaut Insurance Co., underwriter of the professional liability insurance program, sponsored by the Pennsylvania Medical Society, inaugurated Medical Alert Communications (MAC) a new program in the field of medical and nursing education. Although the theme of our new program is simple—"A medical information program dedicated to advancing the quality of patient care"—the purpose and scope of this major new undertaking warrants a brief explanation. To begin with, the idea of a professional liability insurer injecting itself into medical and nursing practice—heretofore deemed sacrosanct—will undoubtedly raise questions from some readers concerning our motives and our ultimate objectives. Let us explore these motives and objectives, then, to see why we believe Argonaut, as one of the nation's largest professional liability insurers, ought to be involved in this type of activity, what our objectives are, and how we propose to achieve them.

Litigation Increasing

Within the past several years the volume of malpractice claims and litigation has been increasing steadily. Professional liability insurance premiums have also increased dramatically during this period. The apparent continuation of these trends is a source of alarm to all health care practitioners and institutions. For the hospital, it is primarily a matter of economics, but for the doctor the spectre of being sued, with all of its attendant emotional trauma, is the harrowing reality which confronts him every day while practicing his chosen profession.

What can be done to stem the tide of malpractice claims and litigation? How can this best be accomplished? Clearly, there is no simple answer, no panacea which will suddenly remove the Sword of Damocles which hangs over every doctor's head. But this is not to say that the situation is hopeless. There are things which health care providers can do to make inroads on this problem. Their liability insurers can (and must) assist in this process.

One fundamental fact must be faced squarely, however, if any real progress is to be made. *All malpractice claims and suits have their genesis in medical treatment.* Once that fundamental fact is comprehended, it follows that primary attention must be focused on the root causes of claims associated with the treatment process itself.

Reducing Risks

In other lines of casualty insurance, carriers commonly devote much attention to finding ways of avoiding or reducing the risks for which coverage is provided. Workmen's compensation carriers have long applied themselves to industrial accident prevention. Products liability insurers have begun to appreciate the importance of helping improve the products whose integrity and safety they insure. The casualty insurance industry has an obligation not only to its insureds, but to society as a whole, to prevent and minimize losses, particularly where such losses affect human lives.

What better reason, then, for a professional liability insurer like Argonaut to exert its energies and utilize its expertise to help reduce the types of harms which arise in medical treatment and cause injuries to patients, whether or not they are attributable to negligent conduct?

Much good work is presently underway in the area of patient safety, fostered in large part by liability insurance carriers for hospitals and other health care institutions. Without question, existing quality control mechanisms and patient safety programs in health care institutions have goals which are parallel with those of the liability insurer, whose prime concern is to reduce the number of professional liability claims and their consequent costs to health care providers. There is a difference, however, between an insurer's safety engineering activities—which are generally limited to factors involving the physical environment of hospitals—and its concern about the quality of medical treatment. The latter is an area generally felt to be outside the purview of non-professionals. But is it, really?

Treatment Complications Costly

Does it make sense for a liability carrier to assume the risk of indemnifying losses over which it can exercise no risk-avoidance efforts whatever? The major losses in the professional liability field always have been those involving serious complications in treatment. It is precisely those types of losses which have caused insurance rates to climb steadily higher. Obviously, an effective patient safety program should concern itself not

only with finding ways to reduce the mechanical and physical hazards in the hospital environment, therefore, but with ways to reduce the many and varied causes of injuries to patients arising out of the treatment process itself.

The HEW Secretary's Commission of Medical Malpractice, of which the writer was privileged to be staff director, made special note of the unique role which the insurance industry could—and *should*—play in developing more sophisticated loss prevention programs in cooperation with its hospital and medical insureds. The MAC program, therefore, represents one company's immediate response to this challenge, and the beginning of what we perceive to be the most effective way of dealing with the ever-growing nationwide malpractice problem.

To Fill Void

Information in MAC articles is intended to fill a void in the literature relating to ways of dealing with:

(1) The direct medical causes of injury to patients

(2) the psychosocial factors in treatment which influence patients to bring professional liability claims

We intend to provide relevant and practical information to the doctor, nurse, hospital administrator, and ancillary health personnel, to assist them in the common goal of making medical treatment safer for all their patients.

We wish to make it very clear, however, that MAC articles will not lay down definitive standards of practice, mandatory guidelines for medical therapy, nursing care, or hospital management. Our objective is simply to convey ideas and information about problems in medical management which are known by some practitioners but need to be conveyed to all. Existing medical literature will be the prime source of the information contained in MAC bulletins. Emphasis will be placed on ways of dealing with the infinite variety of iatrogenic harms commonly occuring in medical treatment.

MAC's board of editorial consultants, representing some of the nations's outstanding authorities in their respective fields, will guide the choice of subject matter and will provide technical direction to assure the pertinence and reliability of all articles dealing with the technical aspects of patient care.

Eli P. Bernzweig, J.D., is vice president—professional liability, Argonaut Insurance Company. Previously he served as director of the Commission on Malpractice of the Secretary of Health, Education, and Welfare.

ROBERT S. SANFORD, M.D., past president of the Pennsylvania Medical Society, installed new officers at the annual convention of the Pennsylvania Society of the American Association of Medical Assistants held in Washington, Pa. The new officers are (right to left) Mrs. Irene Goll, Beaver, president; Mrs. Dorothy Taylor, Levittown, vice president; Mrs. Maxine Apple, Altoona, president elect; Miss Sandra Butkowski, New Castle, recording secretary; and Mrs. Helen Mountjoy, Pittsburgh, treasurer.

Problems To Watch

In the months to come, MAC bulletins will focus on a wide variety of medical treatment problems: medication errors, surgical problems, anesthetic complications, problems involving faulty instrumentation, record-keeping, problems associated with supervision of subordinates, breakdowns in communication (between health care providers and patients and between health care providers themselves), and other sources of injuries and liability claims.

MAC bulletins will not be a source of news about persons, events, or the political aspects of medicine. They will, however, feature a variety of informative and thought-provoking articles of general interest dealing with related topics, including: reduction of the costs of claims handling, evaluation and improvement of quality controls in hospitals, moral and ethical issues in treating patients, improvements in communications with patients, and similar topics.

Argonaut views the MAC program as a public service to its vast audience of health care professionals in the hospital and medical field. We do not intend to utilize the pages of MAC articles as a forum for any purpose other than advancing the quality of patient care. We firmly believe that we have a social responsibility to do whatever we can to make health care more efficacious and safer for all patients. We will strive for that objective throughout the life of the MAC program.

ACS questions chiropractors' role

The Board of Regents of the American College of Surgeons has issued a statement condemning the inclusion of chiropractic services for reimbursement under medicare and medicaid.

Such inclusion implies that chiropractic services are considered legitimate medical services by the federal government—a designation with which Board of Regents, the college's policy-making body, sharply disagrees.

Calling the situation "congressional endorsement of cultism," the board criticized Congress for having approved such an arrangement over the "wide range of contrary recommendations" which it received from such agencies as the Department of Health, Education, and Welfare; the Task Force on Medicaid and Related Programs; the National Advisory Commission on Health Manpower; and the Health Insurance Benefits Advisory Council.

The board noted that Congress had endorsed chiropractic services despite the fact that it was "ostensibly concerned with high quality medical care (and) often critical of the medical profession's own efforts in this regard."

Citing the college's historical goal to improve the care of surgical patients, the board said that the college would be derelict if it did not protest in this instance.

The regents endorsed the American Medical Association's statement on chiropractic, which says, in part, "It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation."

The fundamentals of chiropractic are now being studied at the request of Congress by the National Institute of Neurological Diseases and Stroke, in cooperation with the Engineering in Biology and Medicine Program of the National Institute of General Medical Sciences.

Jefferson plans family medicine program

A three-year residency program in family medicine has been started by Jefferson Medical College of Thomas Jefferson University, with the first students scheduled to begin their studies in September.

Peter A. Herbut, M.D., university president, said that the new program could lead to model systems in the training and distribution of health care professionals throughout the nation. He pointed out that in some rural and inner-city areas the doctor-to-patient ratio is as critical as one physician for every 12,000 people.

The program will provide for (1) a family medicine curriculum during the four years of medical school followed by a three year residency leading to certification as a specialist in family medicine, (2) the recruiting of medical school candidates from underserved areas in Pennsylvania with a loan forgiveness feature for practicing in areas of need, and (3) a long-range planning office for new health care delivery systems funded by a grant by the Robert Wood Johnson Foundation to alleviate the health manpower crisis.

Paul C. Brucker, M.D., will chair the new department at Jefferson, which is the first Philadelphia medical school to initiate such a program. The required clinical experience will be provided through affiliation with Chestnut Hill Hospital (Philadelphia) and Latrobe Area Hospital.

THE INTERNATIONAL Association of Coroners and Medical Examiners met at King of Prussia recently and brought together (left to right) Marvin Aronson, M.D., medical examiner of Philadelphia, program chairman; Donald E. Harrop, M.D., Phoenixville, Chester County coroner and president of the Pennsylvania State Coroners Association; W. Ralston McGee, M.D., Uniontown, Fayette County coroner, newly elected president of the international association; and George E. Hudock, M. D., Wilkes-Barre, Luzerne County coroner. The educational seminar accompanying the meeting was conducted by Temple University School of Medicine. Dr. Harrop is chairman of the Society's Council on Governmental Relations.

All physicians need to know Helling v. Carey result

FRED SPEAKER, ESQ.
Harrisburg

The Supreme Court of Washington has recently decided a malpractice case which merits the careful attention of ophthalmologists and, indeed, all physicians.

The Court held *[*In *Helling v. Carey,* 519 P.2d 981 (Wash. 1974)*]* that ophthalmologists are liable *as a matter of law* for blindness caused by glaucoma which was undetected because the patient was not tested.

A court decision in the State of Washington is, of course, not binding on physicians in Pennsylvania. But the principles enunciated in the case have already received wide professional attention; could find their way into Pennsylvania courts; and, accordingly, can be ignored only at risk.

In the *Helling* case, a woman first consulted partners who practiced ophthalmology when she was 23 years old and was fitted with contact lenses for her myopia. Over the next nine years she consulted with the ophthalmologists some 10 times—with increasing frequency—concerning visual problems which the ophthalmologists believed to be related solely to complications associated with her contact lenses. On the eleventh visit, on the fourth straight month, one of the partners for the first time tested the plaintiff's eye pressure and field of vision; and the test indicated that she had glaucoma.

The court accepted the testimony that the pressure test for glaucoma is not given as a regular practice for patients under the age of 40, since the disease occurs rarely in that age group. It was recognized that the incidence of glaucoma for people under 40 is one case out of twenty five thousand. But the court also acknowledged that the pressure test was simple, relatively inexpensive, and harmless. Accordingly—even though other competent ophthalmologists also did not routinely perform the pressure test for glaucoma—the court held that the test was so simple and the results of a failure to give the test so devastating—that it must always be given.

The significance of the decision is two-fold:

First, there is the imposition of "strict liability" on ophthalmologists. If glaucoma results and could have been detected during previous visits and therefore prevented, the ophthalmologist will be liable for failing to give the tests to detect it.

Second, there is the possibility that, throughout the field of medicine, this concept of strict liability resulting from the failure to apply simple, inexpensive, and harmless tests may be imposed.

Although the decision did not turn on this issue, it may also be significant that there were frequent and repeated complaints by the patient. Such a pattern of patient discomfort may be considered to be enough to put the physician on notice that something is amiss and needs further testing.

THE LEGAL implications of physician involvement in peer review, privilege delineation, utilization review, and medical audits were considered at the second annual medico-legal symposium sponsored by the Delaware County Bar Association and the Delaware County Medical Society recently. Shown (left to right) are: Daniel Ryan, Esq.; Eric Springer, Esq.; Thomas Schroth, M.D., vice president for medical affairs and chairman of the Utilization Review Committee, Crozer-Chester Medical Center; John C. Smith, Esq.; David Smith, Ph. D., professor and chairman, department of political science, Swarthmore College; Howard Richard, Esq.; William Y. Rial, M.D., vice speaker, House of Delegates, American Medical Association; and John W. Lawrence, M.D., chairman, Delaware County Medical Society Peer Review Committee.

Says sigmoidoscopy also needed

Council approves guaiac testing

The 1973 House of Delegates of the Pennsylvania Medical Society directed the Council on Education and Science to "work with the Pennsylvania Division of the American Cancer Society to ascertain the results of their pilot studies (of guaiac testing for occult blood in the stool) and report the results of their studies to the members of the Society, asking them to follow through on implementing such a program through their individual offices." While the Pennsylvania Division of the American Cancer Society has not completed all its testing programs, some results are available and are summarized below.

The guaiac test is relatively inexpensive for the patient. It allows physicians who do not generally use the proctoscope to determine the possible presence of a disorder of the GI tract that may cause internal bleeding. The vast majority of the patients participating did not find the test objectionable. There was, however, some difficulty in having patients adhere to the meat-free diet; this caused in some cases an unusually high percentage of positives.

The pilot studies of the Pennsylvania Division of the American Cancer Society reveal that over 90 percent of the patients participating had never had a proctoscopic examination; a little less than 50 percent were not aware of the dangers of colon and rectal cancer. Guaiac testing thus has both a diagnostic and educational value. If guaiac screening plus digital rectal examination and sigmoidoscopy were included in all annual physical examinations, many more cases of colon and rectal cancer could be detected in a stage amenable to cure. **However, in the opinion of the Council on Education and Science, guaiac testing is not a substitute for sigmoidoscopy.**

The Council on Education and Science urges all physicians to use the guaiac test as a minimum, as a routine part of physical examinations, particularly for those patients over forty-five years.

Because GI bleeding tends to be intermittent, a three-day test series is recommended. Beginning twenty-four hours before the first stool sample is taken, the patient should be on a meat-free, high-residue diet. A recommended diet includes vegetables, fruits, moderate amounts of peanuts and popcorn each day, "All Bran" for the daily cereal, and no meat, fish, or chicken.

PARTICIPANTS in Medical College of Pennsylvania's pioneer part-time residency training program being carried out under a National Institutes of Health Bureau of Health Manpower contract are: (standing, left to right) Drs. Joyce Kay, Mt. Airy; and Susan Jonas, Germantown. Seated (left to right) are Drs. Marilyn LaSovage, East Falls; Florida Olivieri, Mr. Airy; and Selma Balaban, Merion. Dr. Norma Wenger, West Park, is not present.

New residents at Hershey

Milton S. Hershey Medical Center of Pennsylvania State University has announced that fifty-three new residents have joined the house staff and ten house officers have been named chief residents and instructors.

New chief residents and instructors include Edward H. Williams, M.D., cardiothoracic surgery; James E. Crutcher, M.D., family and community medicine; Richard J. Lung, M.D. and Martin J. O'Neill, M.D., general surgery; D. Mark Potter, M.D., medicine; Howard Gillis, M.D., obstetrics and gynecology; Lindell B. Entzminger, M.D., otorhinolaryngology; Paul S. Dickman, M.D., pathology; and Bruce W. Carlin, M.D., urology.

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Society changes format

Educational congress scheduled

An Educational Congress, replacing the former Educational and Scientific Assembly, is being arranged by the Council on Education and Science of the Pennsylvania Medical Society at the Host Inn in Harrisburg, October 23-25.

The Congress will feature two PMS programs and a number of specialty society programs. PMS will present a half-day session, "An Overview on Acupuncture," on Wednesday. The Society will also offer two sessions on "The Physician in a Long-Term Care Facility" on Thursday and Friday.

On Wednesday, October 23, Hahnemann Medical College and Hospital will present an update on its Physician's Assistant Program, and meetings of hospital-based educators and of educational chairmen of the twenty-one state-wide specialty societies will be held.

Specialty society programs scheduled to date include those of the Urological Association of Pennsylvania, on Thursday, and the Pennsylvania Orthopaedic Society which has scheduled an executive meeting and banquet on Thursday. On Friday, the Pennsylvania Orthopaedic Society will hold its scientific and business meetings. Also scheduled for Friday are meetings of the Pennsylvania Psychiatric Society, the Pennsylvania Academy of Physical Medicine and Rehabilitation, the Pennsylvania Society of the American Association of Medical Assistants, the Central Pennsylvania Chapter of the American College of Surgeons, and the Robert H. Ivy Society (plastic surgery). The two latter organizations have also scheduled banquets on Friday evening.

Follow policy on retention of films

The following is a condensation of the American Academy of Radiology policy on the ownership and retention of films as modified by PMS legal counsel.

Roentgenograms are the property of the radiologist or hospital in which they were made and: (1) Should be properly marked and dated; (2) Should be taken out of office or hospital only on "loan" basis; (3) Should be made available to the referring physician and, should that physician change, to any subsequent physicians.

When a medical-legal situation occurs, radiologists should not release involved films, except pursuant to a court order or authorization by patient. When a radiologist is party to such a situation, he may refuse to release films except on court order.

In the case of films made in connection with an inpatient, outpatient, or emergency patient of a hospital, the licensing regulations of the state require that the medical record (films) be kept on file for a minimum of seven years following discharge of the patient. If the patient is a minor, records should be kept on file at least two years after the individual has reached his majority.

State rules provide that medical records may be microfilmed immediately after completion. Microfilming may be done on or off the premises. If done off the premises, the hospital must take precautions to assure the safe keeping of the records. Legal counsel has determined that reductions of x-rays are acceptable and can be admitted as evidence in court. Reductions may be necessary in those instances where storage space is at a premium.

MECO program active

The 1974 Medical Education—Community Orientation (MECO) program in central and eastern Pennsylvania this summer has forty-nine medical students working in twenty-four different communities.

The preceptor program of the Student American Medical Association has placed first and second year students from the University of Pennsylvania, Hahnemann Medical College and Hospital, Jefferson Medical College, Temple University School of Medicine, Medical College of Pennsylvania, Pennsylvania State University College of Medicine (Hershey), and the Philadelphia College of Osteopathic Medicine with physicians to gain primary care experience.

AT THE cornerstone ceremonies for Hahnemann Medical College's new $34 million building, Joseph R. DiPalma, M.D., (front left), senior vice president and dean of academic affairs, officiates as Hahnemann officials and state and national dignitaries look on.

JAMA citation incomplete

New law here controls in transfusions

ROBERT L. LAMB
Director of Communications

According to the column, "Medicolegal Rounds," in the May 6 issue of the *Journal of the American Medical Association* entitled "Recent Decisions on Liability for Transfusion Hepatitis," implied warranties were reported to exist in Pennsylvania in connection with blood transfusions. It cited a 1970 Pennsylvania Supreme Court decision that said in part "even if a blood transfusion is found to be a service and not a sale, implied warranties could be still found to exist."

The article neglected, however, to follow through and point out that in 1972 the Pennsylvania General Assembly enacted House Bill 1266 which became Act No. 9 upon signature by the Governor. Act No. 9 states:

"Notwithstanding any other law, no hospital, blood bank, or other entity or person shall be held liable for death or injury resulting from the lawful transfusion of blood, blood components or plasma derivatives, or from the lawful transplantation or insertion of tissue, bone, or organs, except upon a showing of negligence on the part of such hospital, blood bank, entity or person. For the purposes of this act, negligence shall include but not be limited to any failure to observe accepted standards in the collection, testing, processing, handling, storage, transportation, classification, labeling, transfusion, injection, transplantation or other preparation or use of any such blood, blood components, plasma derivatives, tissue, bone, or organs. Specifically excluded hereunder is any liability by reason of implied warranty or any other warranty not expressly undertaken by the party to be charged."

Society legal counsel says that while this new law has not yet been tested in the courts, it is controlling in Pennsylvania and supersedes the Pennsylvania Supreme Court decision of 1970 cited in the JAMA article.

Hershey's emergency medicine residency grows

The residency program in emergency medicine initiated at the Milton S. Hershey Medical Center of Pennsylvania State University last summer is designed to fill a growing need, especially in mid-state Pennsylvania, according to H. Arnold Muller, M.D., director of Hershey's emergency care unit. The three-year residency is outpatient and ambulatory care oriented.

In addition to fourteen months of emergency care unit training, the residents will spend one month in ophthalmology, neurosurgery, psychiatry, coronary care, intensive care, plastic surgery, dermatology, otolaryngology, administration, and obstetrics and gynecology. They will serve two months in anesthesia and respiratory care, orthopedics, and electives; and three months in pediatrics. A final month will be served in a community or other university hospital emergency care unit.

The faculty is composed of the chiefs (or their representatives) of the various clinical and ancillary service departments. Emergency care unit instruction is provided during daily rounds; x-ray, conferences, morbidity and mortality conferences; and symposia.

Knowledge of community, state, and national emergency care organizations is stressed. First hand experience in ambulance units, helicopter transportation, training of emergency medical technicians, communication systems, and public instruction is part of the program.

The training in emergency medicine made available through Hershey and its affiliated teaching hospitals (such as Harrisburg and Polyclinic Hospitals) is expected to improve the management and treatment of the acutely ill and injured in Southcentral Pennsylvania. Residents from the departments of medicine, surgery, and family practice continue to rotate through and receive training in the emergency care unit of the Hershey medical center.

ACP announces courses

The American College of Physicians (ACP) has announced a series of regional meetings and postgraduate courses designed for internists and physicians in related specialties.

Edward C. Rosenow, Jr., M.D., Philadelphia, executive vice president of ACP said the meetings serve a dual purpose by: (1) providing for dissemination of information on new advances in medical research, and (2) offering a means for physicians to report investigative work and clinical experiences.

The Western Pennsylvania/West Virginia meeting will be held October 11-12 in Pittsburgh. The Eastern Pennsylvania regional meeting is scheduled November 1-3 at the Hershey Hotel, Hershey.

Welcome to Portland, Oregon for the 28th Clinical Convention

November 30-December 4, 1974

"In this age of specialization, there's a vital need for discussion of the broader implications of new-found knowledge. The 28th AMA Clinical is designed for that purpose...to bring together physicians of the various specialties to study and discuss the broader aspects of medicine as they apply to their practices."

Huldrick Kammer, M.D., Chairman
Council on Scientific Assembly

For further details, write:
Circulation & Records Dept.
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

The Role of the Detail Man

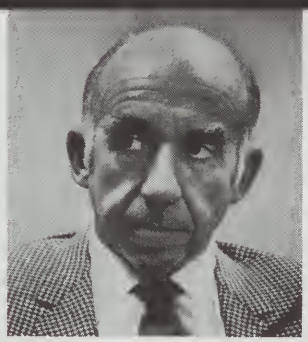
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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editorials

State Society must look ahead

Concern and displeasure has been voiced around the state regarding the recent passage of Act 29, (formerly S.B. 570), the amendments to the Pennsylvania Optometric Practice Act, and the way in which the Pennsylvania Medical Society allegedly handled this legislation. The State Society has been the target of much undeserved criticism in this matter.

Introduced, early in 1973, the amendments permit non-physicians to perform certain procedures which previously were limited only to licensed ophthalmologists. At the October 17, 1973, meeting of the Board of Trustees of the Pennsylvania Medical Society, the members confirmed action to introduce legislation for the Pennsylvania Academy of Ophthalmology and Otolaryngology to amend the Pennsylvania Optometric Practice Act to require referral to a physician in certain instances. These include among others double vision, permanent or temporary loss in the field of vision, inflammation of or about the eye, or presence of opacities in the ocular media.

The Board of Trustees action was referred to the Reference Committee on Governmental Relations of the 1973 House of Delegates. The recommendation of the Reference Committee was to oppose S.B. 570, but if it appeared that S.B. 570 had sufficient support in the legislature, the Society would then offer amendments to make it safer. "We feel that under the circumstances, the Society is acting in a logical legislative manner recognizing that the bill, if it does become active, should be amended further which is the feeling of your committee —further, your committee recommends that these additional amendments should include language similar to the proposal in Supplemental F [Board of Trustees recommendation]."

Lobbying has been a part of the American political scene since the days of Sam Adams, who did most of his wirepulling from the Green Dragon Tavern in Boston. Lobbyists attempt to influence legislation but have no direct political responsibility. They may do so by simply presenting the wants and ideas of the group they represent to the legislator. If the situation is a complex one, the lobbyist may provide facts and opinions. Most of all, the lobbyist disseminates information and serves as an expert in the field he represents. Our Pennsylvania Medical Society lobbyists have done a commendable job in this respect. There are, unfortunately, instances in which personal feelings and political alliances enter into the processes of lawmaking and no amount of lobbying or reason can change opinions. Lawmakers of the quality of Edmund Ross, who looked into his own political grave when he refused to recognize the right of others to demand that he vote either for or against the conviction of Andrew Johnson, are rare.

The State Society, through House of Delegates action, clearly opposed the amendments to the Pennsylvania Optometric Practice Act. Our best efforts to prevent passage of this bill failed. We must now turn our attention to ways to amend and modify the law instead of wasting time by pointing accusing fingers at each other.

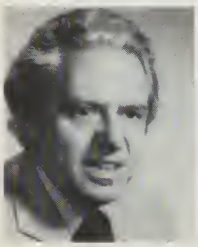
David A. Smith, M.D.
Medical Editor

. . . About all I need to know today, Vern, is where I can get a pair of sunglasses like that?

M.D.s in the news

William P. Coghlan, M.D., chairman of the department of surgery at the Medical Center of Beaver County, presented a paper recently on "Abdominal aortic aneurysms in the community hospital" at the American College of Surgeons meeting at White Sulphur Springs, W. Va. He is a fellow of the American College of Surgeons and is certified by the American Board of Surgery and the American Board of Thoracic Surgery.

Leonardo Magran, M.D., Melrose Park, has been appointed chairman of the division of child psychiatry at the Northern Division, Albert Einstein Medical Center. He is a fellow of the American Academy of Child Psychiatry and the American Psychiatric Association.



DR. MAGRAN

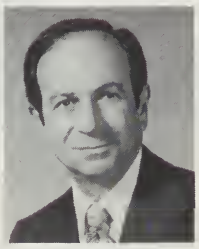
DR. SCHEIE

Harold G. Scheie, M.D., chairman of the department of ophthalmology of the University of Pennsylvania School of Medicine and director of the Scheie Eye Institute was the recipient of an Horatio Alger Award presented by the American Schools and Colleges Association in New York recently. The awards are made to people in all walks of life whose careers typify results of individual initiative, work, and honesty. Young college leaders and college presidents select recipients to reinforce the concept that basic principles still count in the lives of American leaders.

John Y. Templeton, III, M.D., Rosemont, was guest speaker at the Benjamin Lipshutz Memorial Surgical Lectureship at the Daroff Division of the Albert Einstein Medical Center, Philadelphia, recently. Dr. Templeton is professor of surgery at Jefferson Medical College, Thomas Jefferson University, and president of the Philadelphia County Medical Society and the Philadelphia Academy of Surgery.

Aaron Bannett, M.D., Philadelphia, has accepted the permanent chairmanship of the division of surgery at Albert Einstein Medical Center, Northern Division. He is clinical associate professor in surgery at Temple University School of Medicine. Dr. Bannett has headed Northern Division's surgical transplant unit since its inception in 1966. He is chairman of the Transplant Committee, Greater Delaware Valley Regional Medical Program, president of the Greater Delaware Valley Society of Transplant Surgeons, and a member of the board of directors of the Delaware Valley Kidney Foundation.

DR. BANNETT



DR. MEYER

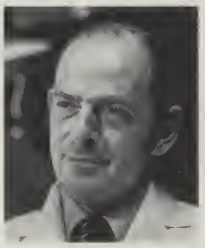
Harold Meyer, M.D., has been appointed chairman of the division of pediatrics at Albert Einstein Medical Center's Northern Division. He is associate professor of pediatrics and of community medicine at Temple University School of Medicine and attending physician at St. Christopher's Hospital for Children.

T. Terry Hayashi, M.D., Pittsburgh, has been appointed chairman of the department of obstetrics and gynecology at the University of Pittsburgh School of Medicine and chief of obstetrics and gynecology at Magee-Womens Hospital, University Health Center of Pittsburgh. He is a member of the American College of Obstetricians and Gynecologists, the American Gynecological Society, the Society for Gynecologic Investigation, and the American Society of Biological Chemists. He is a diplomate and examiner of the American Board of Obstetrics and Gynecology.

Harry Prystowsky, M.D., provost and dean of the Milton S. Hershey Medical Center, Pennsylvania State University, has been appointed to Governor Shapp's Committee on Health Education.

John Silverio, M.D., Berwyn, spoke recently over the Louisiana Hospital television closed circuit medical education unit beamed to fourteen hospitals in the state of Louisiana. Two of the three programs employed a "talk back" system enabling two-way communication with the receiving hospitals. Dr. Silverio, who is Wyeth's director of clinical nutrition, is a fellow of the American Academy of Pediatrics and assistant professor of pediatrics at the University of Pennsylvania School of Medicine.

DR. SILVERIO



DR. ASBURY

The neurology department at the University of Pennsylvania School of Medicine has a new professor and chairman, **Arthur K. Asbury, M.D.**, who comes from the neurology department of the University of California in San Francisco. He succeeds **Lewis P. Rowland, M.D.**, who left his post to become chairman of neurology at Columbia University. Dr. Asbury has brought with him two former members of the San Francisco faculty: **Austin J. Sumner, M.D.**, who will be assistant professor of neurology specializing in the physiology of peripheral nerve disease, and **Mark J. Brown, M.D.**, associate in neurology, whose main interest is in nerve damage from diabetic neuropathy. Dr. Asbury is a fellow of the American Academy of Neurology. He is a member of the American Neurological Association, the American Association of Neuropathologists, and the Society of Neuroscience.

An Allentown physician, **Francis M. Krakowski, M.D.**, has been appointed as one of the first scholars of the Robert Wood Johnson Clinical Scholars Program at the University of Pennsylvania School of Medicine. The foundation has given a $720,099 three-year grant for physician training to develop health care delivery and educational systems. **Samuel P. Martin III, M.D.**, professor of community medicine and health care systems, will direct the program.

Carl W. Konvolinka, M.D., associate in the department of surgery at Geisinger Medical Center, has been elected vice chairman of the Susquehanna Emergency Medical Services Council. He is chairman of the Geisinger Disaster and Emergency Room Committee and director of trauma services.

Herbert Kaufmann, M.D., radiologist-in-chief at Childrens' Hospital of Philadelphia and professor of radiology at the University of Pennsylvania School of Medicine, presented two papers recently—one at the European Society for Pediatric Radiology in Helsinki, Finland—the other was the Leo G. Rigler Lecture in Tel Aviv, Israel.

Simon Kramer, M.D., chairman of the department of radiation therapy and nuclear medicine at Jefferson Medical College, Thomas Jefferson University, will direct a three-year study for the American College of Radiology to evaluate radiation treatment for cancer and set up treatment guidelines. The study has been made possible by a National Cancer Institute grant.

John A. Waldhausen, M.D., chairman of the department of surgery at Milton S. Hershey Medical Center of Pennsylvania State University, has been elected president of the central Pennsylvania chapter of the American College of Surgeons (ACS). William DeMuth, M.D., professor of surgery, was reelected to the board of governors of ACS.

Alfred M. Bongiovanni, M.D., endocrinologist at Childrens' Hospital of Philadelphia, has been named chairman of the Council of the American Pediatric Society, Inc. He is professor of pediatrics at the University of Pennsylvania School of Medicine.

Erwin R. Smarr, M.D., Wynnewood, has been appointed director of professional education of the Philadelphia Psychiatric Center. He is assistant clinical professor of psychiatry at Jefferson Medical College, Thomas Jefferson University, director of professional education at Haverford State Hospital, and attending psychiatrist at Bryn Mawr Hospital.

Joseph Leighton, M.D., professor and chairman of the department of pathology at Medical College of Pennsylvania, has been appointed to a four-year term on the National Scientific Advisory Committee for Diagnosis and Therapy for the American Cancer Society.

John Paul Brady, M.D., has become permanent chairman of the psychiatry department at the University of Pennsylvania School of Medicine, succeeding **Albert J. Stunkard, M.D.** He has also been named Kenneth E. Appel Professor of Psychiatry. He is co-founder and associate editor of *Behavioral Therapy* and has done extensive work in the application of behavior therapy in treating stuttering.

Special Citations

Doris G. Bartuska, M.D., East Falls, and **Sunder H. Mansukhani, M.D.**, Wynnewood, were recipients of Christian R. and Mary F. Lindback awards for distinguished teaching at the Medical College of Pennsylvania's recent commencement ceremonies. Dr. Bartuska is associate professor of medicine and assistant professor of pathology, and Dr. Mansukhan is assistant professor of pathology at MCP.

Hobart A. Reimann, M.D., has received the Reverend Clarence E. Shaffrey, S. J. Award from the Medical Alumni Association of St. Joseph's College for his contributions in the fields of viral and mycoplasmal pneumonias, periodic disorders, and viral dysentery. He is associate director of medical affairs and professor of medicine at Hahnemann Medical College and Hospital.

Peter Randall, M.D., director of Facial Reconstruction Center at Childrens' Hospital of Philadelphia and professor of plastic surgery at the University of Pennsylvania School of Medicine, is the recipient of the American Cleft Palate Association's Service Award. He is the first plastic surgeon to receive this honor.

George P. Rosemond, M.D., professor of surgery at Temple University Health Sciences Center, has received the 1974 Humanitarian Award from the Philadelphia Division of the American Cancer Society. Dr. Rosemond is past president of the Pennsylvania Medical Society and vice president and president elect of the National American Cancer Society.

Ira W. Gabrielson, M.D., Newton Square, has been named an Outstanding Educator of America for exceptional service, achievement, and leadership in the field of education. He is professor and chairman of the department of community and preventive medicine at Medical College of Pennsylvania.

Paul T. Milnamow, M.D., president of the medical staff of St. Luke's and Children's Medical Center, Philadelphia, has been awarded the Legion of Merit for exceptional conduct in the U.S. Medical Corps for the past thirty years. He was cited for having "contributed significantly to the overall success of the mission of supervising the control and training of subordinate medical units.

Walter P. Bitner, M.D., Harrisburg radiologist, was honored recently by having the keynote oration at the annual meeting of the Pennsylvania Radiological Society at the Hershey Hotel dedicated to him. Dr. Bitner is director of the School of Radiologic Technology at Harrisburg Hospital.

John A. Hargleroad, M.D., director of university health services at Pennsylvania State University, has been elected to fellowship in the American College Health Association.

Coming next month ...

a new continuing medical education reference

pennsylvania medicine
SEPTEMBER 1974

PENNSYLVANIA MEDICINE's own

continuing medical education supplement

will contain:

1. *Announcements* (by location) of most of the continuing medical education activities that will be held this fall in Pennsylvania.

2. *Calendar Listings* of the Category One education activities.

3. *Subject Index* to help you locate educational activities in your particular specialty.

Watch for the September edition of PENNSYLVANIA MEDICINE!
Locate the continuing medical education supplement on special pages.
File the supplement for future reference.

For more information, contact: Council on Education and Science
Pennsylvania Medical Society
20 Erford Rd.
Lemoyne, Pa. 17043

Continuing education...
now a PMS membership requirement

I. Scientific Sessions

The role of the practitioner in the treatment and preventative management of cardiovascular disease is the theme of the 24th Annual Scientific Sessions of the American Heart Association, Pennsylvania Affiliate.

II. Time/Place

The sessions will be held September 27-28, from 9:00 A.M. to 4:30 P.M., at the Hershey Motor Lodge and Convention Center (opposite the Medical Center), Hershey, Pa.

III. Subjects

Presentations and discussion of cases will cover:

A. Hypertension
1. Epidemiology
2. Diagnostic Evaluation
3. Pharmacologic Treatment

B. Hyperlipidemia
1. Recognition of Clinical Forms
2. Treatment

C. Arrhythmias
1. Recognition
2. Ventricular and Atrial Arrhythmias in the Coronary Care Unit
3. Preventative Approach to Serious Arrhythmias
4. Epidemiology of Sudden Death

IV. Faculty

James H. Gault, M.D., Lancaster, Chairman
J. Thomas Bigger, Jr., M.D., New York City
Karl Engelman, M.D., Philadelphia
Arthur H. Hayes, Jr., M.D., Hershey
John A. Kastor, M.D., Philadelphia
Marvin Moser, M.D., White Plains, N. Y.
Arthur J. Moss, M.D., Rochester, N. Y.
Robert S. Shulman, M.D., Bethesda
Milford G. Wyman, M.D., San Pedro, Cal.
Robert Zelis, M.D., Hershey

V. Credits

This continuing medical education activity is acceptable for 14 credit hours in Category I for the Physician's Recognition Award of the AMA and PMS; 14 hours of elective credit by the AAFP; 14 hours of credit by the ACGP in Osteopathic Medicine and Surgery.

VI. Fee

Registration fee: $40 plus luncheons, if desired, at $6 each. Medical students, residents and interns are exempt from the registration fee.

Contact

American Heart Association, Pennsylvania Affiliate, at P.O. Box 2435, Harrisburg, Pa. 17105 . . . or your local Chapter.

Health care in Pennsylvania—1974

the position of the Pennsylvania Medical Society as presented to the major political parties in the state for their consideration in the drafting of their respective party platforms as they relate to the health care of the people of the Commonwealth adopted by the Board of Trustees and Councilors May 15, 1974.

Strong Department of Health

Fundamental to the health of the citizens of the Commonwealth is the establishment and maintenance of a strong Department of Health. Since 1948, the Pennsylvania Medical Society has advocated a stronger Department of Health. Implicit in this statement is the return to the jurisdiction of the department of all health services. In this regard there have been some encouraging changes, which include transfer of the licensing of hospitals and the Hill-Burton operation to the Department of Health. There is also the proposal under discus-

Commonwealth of Pennsylvania

DEPARTMENT OF HEALTH

HARRISBURG

sion of moving the health professions' licensing boards to the Department of Health.

The Pennsylvania Medical Society calls for the adequate staffing of the Department of Health with health professionals. It views the secretaryship not as a political plum, but as a vital link in maintaining the safety and health of the citizens of the Commonwealth. The office of the Secretary of Health requires a skilled, experienced, properly trained and qualified doctor of medicine. The Pennsylvania Medical Society urges that the Department of Health and the office of the secretary be given the priority required by the health needs of the citizens.

Physician Distribution

The Pennsylvania Medical Society reports that there is an uneven clustering of physicians in the Commonwealth. The trend toward specialization in the pursuit of quality medical care has been encouraged by third party payment mechanisms, federal government subsidies, and prestige in the eyes of the public and the profession. This has resulted in a downward trend in the number of family practitioners in the nation and Pennsylvania. Anecdotal evidence, the requests to the Society's Physician Placement Service, and most studies that have been done point to a need for additional numbers of family physicians in Pennsylvania and the nation as a whole.

There is also a geographic maldistribution of physicians. This is less certain than specialty maldistribution, because physician-to-population ratios based on county lines do not reflect referral patterns, but the bulk of the evidence available points to a geographic maldistribution.

In brief Pennsylvania needs: (1) more primary care physicians, and (2) more physicians in rural areas.

The solutions we propose are designed to not only ensure adequate numbers of family physicians and more physicians in rural areas, but to retain also a greater number of these types of physicians in Pennsylvania.

(1) There should be a family physician on medical school admissions committees; special consideration should be given by admission committees to Pennsylvania residents and especially those from rural areas. Tuition should be higher for out-of-state students.

(2) There should be family practice departments in all Pennsylvania medical schools and efforts made or continued to expose medical school students to community medicine in their undergraduate years.

(3) The number of graduate medical education slots available to train family practice residents should be increased; medical schools should affiliate with community hospitals to re-

distribute residencies around the state; community hospitals should seek affiliation with medical schools.

(4) There should be demonstration money from the legislature to establish family practice residencies in need areas.

(5) There should be locum tenens arrangements between rural physicians and medical schools.

Although all of the above recommendations play a role in redistributing physicians in the Commonwealth to serve the areas of need, probably none is more important than the redistribution of residency programs. Residencies are much more important than the home state or the location of the medical school in determining where a physician will practice. A large majority of the graduates of a residency will practice in the same state as the residency; most of these will practice in the same general geographic area. Such considerations are the basis of state funding for the Indiana Plan of Medical Education and similar efforts being made in other states.

It is interesting to note that in terms of the total number of practicing physicians in Pennsylvania, the Commonwealth would appear on the basis of federal statistics to be above the national average. The problem is one of getting the right physician to the right place at the right time.

Financing

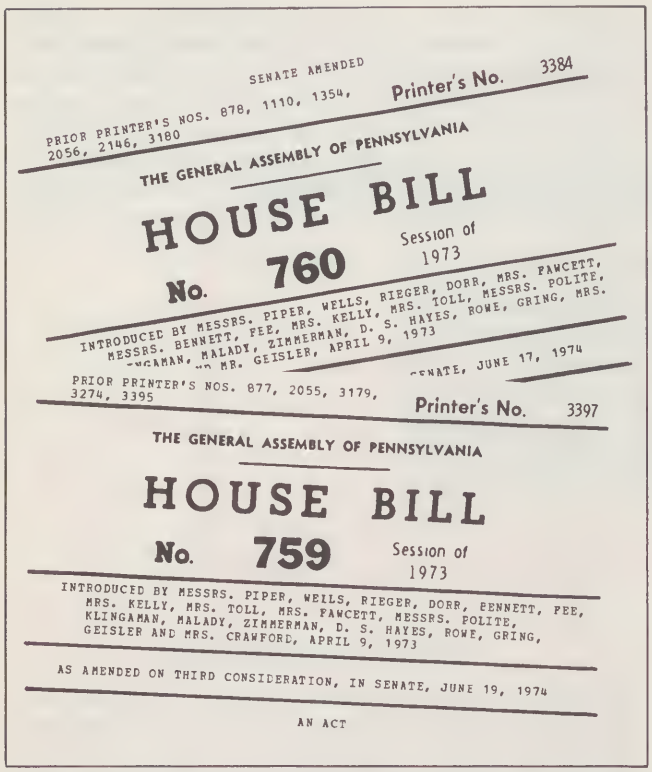
The Pennsylvania Medical Society recognizes that the financing of a medical education is the most costly of all the professions. The Institute of Medicine of the National Academy of Sciences in March of this year put the cost of a medical education at $12,650 a year per student. The Association of American Medical Colleges

gave a range of $16,000 to $26,000. Due to the unrelenting expansion of medical knowledge, this problem will grow. Increased state and federal money will be needed if we are to produce an adequate supply of physicians. The alternative would be to restrict the profession to sons and daughters of the rich. The dilemma for public officials will be to find that balance of public funds to, and accountability of, medical schools and medical students which encourages enrollment but does not smother the profession with discriminatory and capricious regulations. We must develop formulas which encourage the production of sufficient numbers and kinds of physicians to handle the requirements of the Commonwealth, but do not destroy the academic freedom of our medical schools. To lesser degrees, federal and state governments supply aid to public and private colleges and universities training lawyers, architects, engineers, teachers, and other professions; but presently there is required no special accountability from these persons other than their payment of taxes.

Medical Practice Act

One of the constitutional duties of government is to protect its citizens in areas where they could not be expected to protect themselves. It is under such authority that the profession of medicine is a licensed profession controlled by the Medical Practice Act. The age of consumers notwithstanding, it is the Pennsylvania Medical Society which twice in the past ten years has come to the legislature and recommended the act be brought up to date to adequately protect both the profession and the public. Such a revised act carries with it increased disciplinary powers and a consumer member of the medical board. The Society has once again evidenced its concern by drafting and securing passage of this legislation (House Bills 759 and 760.)

The Society reiterates its position taken on January 10, 1973, by the Board of Trustees calling for adequate funding and staffing of the medical board. Unenforced legislation can be worse than none at all, for it cheats the public by promising protection which is undelivered. There is no more scathing indictment of the present inadequacies of the Bureau of Professional Occupation and Licensure than the testimony given by the former commissioner Vincent Fumo before Insur-



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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 760 Session of 1973

INTRODUCED BY MESSRS. PIPER, WELLS, RIEGER, DORR, MRS. FAWCETT, MESSRS. BENNETT, FEE, MRS. KELLY, MRS. TOLL, MESSRS. POLITE, KLINGAMAN, MALADY, ZIMMERMAN, D. S. HAYES, ROWE, GRING, MRS. GEISLER, APRIL 9, 1973

SENATE, JUNE 17, 1974

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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 759 Session of 1973

INTRODUCED BY MESSRS. PIPER, WELLS, RIEGER, DORR, BENNETT, FEE, MRS. KELLY, MRS. TOLL, MRS. FAWCETT, MESSRS. POLITE, KLINGAMAN, MALADY, ZIMMERMAN, D. S. HAYES, ROWE, GRING, GEISLER AND MRS. CRAWFORD, APRIL 9, 1973

AS AMENDED ON THIRD CONSIDERATION, IN SENATE, JUNE 19, 1974

AN ACT

ance Commissioner Denenberg at his health care hearings in Philadelphia on September 25, 1972. There is no evidence that the situation he described has improved since.

Let the record clearly show that the Pennsylvania Medical Society has been a lone voice calling for the adequate funding and staffing of the medical board. Let the record show that in this regard the State Society has been the only true consumer advocate. Let the record show that the Pennsylvania Medical Society has lobbied both on the Hill and with the administration to provide substance to the form of the Medical Practice Act. Let the record show that in election year 1974, the Medical Society again calls upon both parties to put consumers first by adequately funding and staffing boards of licensure for not only the health professions, but all occupations and professions.

Physicians' Assistants

The Pennsylvania Medical Society recognizes that specially trained medical personnel can, with proper supervision, help a physician give comprehensive medical care to his patients and in some cases even increase the number of patients served. In 1971 the Pennsylvania Medical Society joined the American Medical Association and the American Hospital Association in calling for a moritorium on licensure, such moritorium to include the licensing of physicians' assistants. Does this mean these organizations are against PAs? No. As a matter of fact, the AMA has prepared with various specialty boards the "essentials" for an approved curriculum for physicians' assistants. A national certifying exam for PAs has been developed under the supervision of organized medicine.

Immunity For Peer Review

In this election year and the years ahead you will hear the term "peer review" increasingly. It refers to physicians, frequently by specialty, reviewing the work of their peers. The Pennsylvania Medical Society is a leader in peer review, having published the first booklet on utilization review committees back in 1958. Subsequently it organized physician review committees from groups of hospitals to review problem cases for Blue Cross of Western Pennsylvania. Today one form of peer review carried out by the Pennsylvania Medical Society occurs in twenty-one specialty committees provided by the specialty societies in Pennsylvania to review disputed claims submitted by third parties.

The arena, however, in which the public will hear the most about peer review will be in the 317 hospitals in Pennsylvania.

Already the vast majority of these hospitals are conducting types of review aided by computer statistical services, such as the Commission on Professional and Hospital Activities from Ann Arbor, Michigan, and the Hospital Utilization Project from Pittsburgh. These services provide summaries of the medical activities in the subject hospital. Through these statistical reports it is possible to determine, for example, the average length of stay for a type of operation or medical condition and to compare it to other similar hospitals.

These services also can take data abstracted from the medical record and display it in the form of a periodic medical audit so that the medical staff may view in total how it is handling various surgical procedures and medical conditions.

There are several reasons why you will become increasingly aware of peer review. One of these is the fact that the vast majority of hospitals in Pennsylvania voluntarily seek accreditation from the Joint Commission on the Accreditation of Hospitals. In 1970 the Joint Commission revised its standards to require that hospital medical staffs be able to document that they are systematically reviewing the performance of the medical staff.

A second reason that you will hear more about peer review is the fact that the federal government, as a purchaser of medical services for millions of Americans, is in a position to dictate the terms under which it will purchase these services. In 1972 one of a large number of amendments which passed Congress

amending the Social Security Act was Section 249F, known within the profession as the Bennett Amendment. This amendment requires that review organizations be set up across the state (twelve areas in Pennsylvania) composed of practicing medical doctors and osteopaths whose responsibility it will be to review the quality of care provided to government beneficiaries in the hospitals in their Professional Standards Review Organization (PSRO) area. While final review authority lies outside the walls of the hospital in the PSRO area, the PSRO is empowered to authorize the hospital medical staff to carry out its own peer review, provided that review meets the standards of the PSRO.

These several paragraphs have brought us down to the core of the peer review which must take place within each hospital. If such peer review is to work, the physicians on that staff must be free to review peer performance objectively and to make the necessary recommendations on education programs and perhaps even restriction of privileges for some physicians. To carry out this peer review, they must not labor under the fear of suit. Immunity from suit must be provided for physicians engaged in legitimate peer review activity, and peer review records must be protected. The Pennsylvania Medical Society has secured passage of HB 1729 which provides peer review immunity. Passage of this bill permits not only proper functioning of peer review committees in hospitals, but also aids peer review activities of county medical societies and the Pennsylvania Medical Society with regard to enforcement of medical ethics and will ultimately aid the enforcement of the Medical Practice Act.

Pennsylvania Medical Care Foundation

The Pennsylvania Medical Care Foundation is a nonprofit corporation organized by PMS to represent its physicians in the design and operation of cost and quality control programs.

On June 10, 1973, the PMS House of Delegates assigned to the Foundation the responsibility as Society spokesmen for PSRO. On April 1, 1974, the Foundation entered into a contract with HEW to establish the first statewide Peer Review Advisory Center. The nearly quarter of a million dollar, year-long contract calls for the Foundation to help the twelve PSRO areas in Pennsylvania get organized and to provide, upon request, assistance to hospital medical staffs in the design and implementation of utilization review and quality appraisal systems which will synchronize with the requirements for the PSROs.

The House of Delegates also authorized the Foundation to be its spokesman on the subject of predischarge utilization review (PDUR) with the Department of Welfare.

Continuing Education

The Pennsylvania Medical Society is a leader in continuing medical education. By amending its bylaws in 1971 to require that physicians continue their medical education if they wish to remain members in good standing of the Pennsylvania Medical Society, PMS became the second state medical society in the country to demand continuing education of its members. The instruments adopted by the Society as fulfilling this requirement are the Physician's Recognition Award of the American Medical Association and the "Certification for Re-election" of the American Academy of Family Physicians. The AMA Physician's Recognition Award calls for a minimum of 150 hours of continuing education every three years, of which sixty hours must be in Category One credits available only from accredited institutions.

The Pennsylvania Medical Society notes that a trend emerging among the national specialty boards in their discussions of recertification is the inclusion of a continuing education requirement. The Society sees continuing education as the most viable instrument currently available to promote and ensure the continued scientific advancement of practicing physicians. The Society pledges to maintain its leadership in this area and sees a role for government only if private voluntary programs should fail.

Medical Assistance Program

While the Society's list of grievances against the Medical Assistance Program is long in both number and duration, there is one overriding problem which dwarfs the others. It is the insistence of the Department of Welfare in making payments to physicians for services rendered in their offices through DPW's own bureaucracy. In this day of computers, only government could pay its bills six to nine months after the fact, in a lump sum check, with no indication as to which specific services are being paid. There are enough problems in delivering medical care to the poor without compounding the issue through administrative ineptitude. This is all the more ironic when there exists in Pennsylvania the largest Blue Shield company in the world, capable of handling payments to physicians not only for Pennsylvanians, but for national companies operating in every state and the federal government itself. The Pennsylvania Medical Society reiterates its recommendation of many years that the Department of

Welfare contract with Blue Shield to administer the system of payments due physicians for services rendered out of the hospital to MA patients.

It should come as no surprise that some physicians choose not to treat welfare patients simply because of the bureaucratic "never, never land" into which they must enter.

The Society recognizes with approval the increase from $4 to $6 made by the Department on office visits for MA patients and the increase from $5 to $7 for an MA home visit, but notes that the cost of rendering the service often exceeds the DPW allowance.

The Society notes the activities of the Department of Welfare with regard to its development of a predischarge utilization review program (PDUR). The Society recognizes the need to eliminate or at least reduce retroactive denials on the admissions and stays of MA patients because of the severe financial stress it causes hospitals. PMS advises that the department must also perform in compliance with federal law. In this regard, we believe Congress clearly intended to impose professional standards review organizations over both medicare and medicaid patients. The utilization review and quality appraisal systems, developed for and compatible with the Bennett Amendment, must therefore take precedence over PDUR. Or at the very least, PDUR must be modified to meet the minimum requirements for PSRO.

Hospital Costs

While the Pennsylvania Medical Society recognizes that the costs of hospital services are a legitimate concern of all citizens of the Commonwealth, the Society urges extreme caution in the development of legislative relief. The Society notes that in the omnibus amendments to Social Security (in 1972) were included sections designed to offer incentive payments to hospitals for services to medicare patients and to impose financial penalties on hospitals which disregard comprehensive health planning recommendations. The Society advises against state certificate of need legislation until the ramifications of existing federal statutes are known.

The Society is on record (and has so testified) as being in favor of hospital licensure and uniform accounting legislation. However, the Society is also aware that surprising initiatives have occurred in other states where hospital control legislation has already been passed. Sometimes it has been used to attempt to control the construction of offices of private physicians. In others, it has been used to attempt to dictate to hospitals the closing of certain departments of the hospital.

Recent federal experience at price control has been very disappointing. The nation has become disillusioned with government price control.

The Society notes that 1973 saw the passage of a federal Health Maintenance Organization Act with a $375 million price tag. The Act will affect every employer of twenty-five persons or more. Since the Health Maintenance Organization must provide comprehensive services on a prospective rate basis, it too will have an effect on costs.

These are some of the reasons why the Society urges extreme caution with regard to hospital cost legislation.

Mental Health

The Pennsylvania Medical Society recommends that a separate Department of Mental Health/Mental Retardation, established under the direction of a qualified psychiatrist, would best serve the needs of the citizens of the Commonwealth. An acceptable alternative to this would be an umbrella department concept of human services with separate and equal offices for Health, Welfare, and Mental Health.

While recognizing the need to safeguard the constitutional rights of all persons, the Pennsylvania Medical Society is also acutely aware of those instances in which the civil rights of a patient are in conflict with his and society's health needs. The Pennsylvania Medical Society recommends that Section 404 of the Mental Health and Mental Retardation Act of 1966 again be literally interpreted in accordance with its original intent to permit a protesting patient to be committed on the signatures of two physicians so that the patient's right to immediate treatment may be honored.

Professional Corporation Tax

During 1973 many Society members who formed professional corporations under the 1971 Professional Corporation Act found that the Department of Revenue refused to accept the value they had assigned to their corporate stock. In each case, the department arbitrarily reassessed the stock at a higher value. The Society does not find within the law any justification for this action and has challenged the department. The Society believes its members are being discriminated against and is pursuing this matter in Commonwealth Court.

Emergency Medical Services

Major progress has been made in developing emergency health service councils as recommended in the Society's 1971 white paper on emergency medical care. These councils should be the instruments at the local level to improve emergency services.

Some aspects of the emergency medical system for Pennsylvania would benefit by the passage of legislation. A good case in point are the areas of minimum

standards for ambulance services, vehicle design, training for attendants, and equipment standards. The Society supports legislation in these areas which brings Pennsylvania into conformance with national standards and which provides for input from the existing volunteer emergency medical resources of the Commonwealth, but rests ultimate medical decisions with the Secretary of Health.

The Society sees the need for a statewide Emergency Medical Service (EMS) council composed of representatives of the major agencies interested in improving emergency medical care. Such a council, the Society believes, should be a creature of the state government and speak with its authority. Among its responsibilities would be (1) the setting of standards where necessary; (2) coordination between agencies of state government and EMS councils; (3) provision of recommendations to the legislature and the governor regarding EMS needs in Pennsylvania.

The Society notes that the Office of Emergency Health Services in the Department of Health has received no increase in its budget or personnel recently, despite increased responsibility for the

growing number of EMS councils. The Society urges the proper funding and additional staffing of the Office of EMS Health Services.

Disaster Planning

Coordination, communication, and control are necessary for adequate response to disaster. The Pennsylvania Medical Society believes that the present state disaster system has not responded adequately to the medical aspects of recent emergencies, such as tropical storm Agnes and the 1974 gas strike. The emergency medical service councils recommended by PMS should also be the vehicles for responding to disasters, because disaster preparation is essentially the same as that for delivering emergency medical care.

The Pennsylvania Medical Society has joined the Hospital Association of Pennsylvania (HAP) in urging that a medical annex to the present state disaster plan be developed in consultation with PMS and HAP.

The Pennsylvania Medical Society also recommends a thorough re-examination of the staffing and organization of the State Civil Defense Council. There is a need for a physician to have official membership and voice so that the emergency and disaster health needs of patients may be adequately represented.

HMOs

While the Pennsylvania Medical Society has not established specific policies on Health Maintenance Organizations (HMOs) as defined by legislation, the Society has approved guidelines from Pennsylvania Blue Shield on per capitation group practice. The 1970 House of Delegates elaborated by approving the guidelines, but cautioned that such approval should not be construed as an action to exclusively support or approve prepaid group practice.

The Society prefers a multiplicity of delivery systems, encourages experimentation, and views the HMO as a modality which needs further development.

Malpractice Insurance

According to the report issued by the HEW National Commission on Malpractice, Pennsylvania is experiencing about a thousand new incident files per year. At the time of the study this was about an eight percent increase per year (below the national average of ten percent).

As early as 1968, the Pennsylvania Medical Society officially recognized a growing malpractice problem in the Commonwealth and began to systematically study it through a mail survey of every member. The Society then determined the parameters of an ideal malpractice insurance program and sought to interest companies in offering such a program. The fruit of this research was harvested on June 1, 1971, when the Society's presently endorsed program was begun with the Argonaut Insurance Company of California administered through Parker and Company of Pennsylvania (now Frank B. Hall & Co. of Pennsylvania, Inc.) The agreement called for a Society commission on professional liability insurance to be responsible for the administration of the program. It also called for the concur-

rence of the commission before any member could be turned down or canceled. The commission also receives the opportunity to review financial data from Argonaut to determine the performance of the program.

As of July 1974, Argonaut had written about 3,500 members of the Society—or about one-third of the membership. The PMS-Argonaut format has become a model used by Argonaut to write malpractice insurance in cooperation with other state medical societies. In 1974 the Argonaut Insurance Company began its Medical Alert Communications (MAC), a continuing education home study course written by nationally known experts as part of a nationwide loss prevention program, the first of its kind in the industry.

The Society has for the past several years supported experimental efforts with the Bar Association and the Hospital Association and other interested parties to reduce the number of cases and to find new ways of expediting existing cases.

Pennsylvania Blue Shield

Pennsylvania Blue Shield is acknowledged to be the largest insurance plan of its kind in the world. In much of the Blue Shield literature will be found references to Blue Shield as the "doctor's plan." This term is largely historical and refers to the founding forces of Blue Shield in 1939. At that time the Pennsylvania Medical Society took the initiative to organize Blue Shield, sponsoring the enabling legislation and providing the original start-up money. Blue Shield grew dramatically for many reasons, including two which the Pennsylvania Medical Society views as overridingly important. From the beginning, Blue Shield enjoyed perceptive leadership, both at the administrative level and the board level. As is well known, that board for many years was composed totally of physicians. To this day it is dominated by physicians.

Because of Medical Society involvement in the organization of Blue Shield, Pennsylvania physicians developed trust and confidence in Blue Shield. This confidence is still manifest in the high number of physicians who are participating members of Blue Shield and who at the time the prevailing fee program was launched were willing to accept as payment in full a fee determined by Blue Shield.

The Pennsylvania Medical Society believes that it is in the long term interest of patients to have a nonprofit medical insurance program which enjoys wide acceptance by the medical profession. The Society favors the retention of a physician majority on the Blue Shield Board.

The Pennsylvania Medical Society finds no evidence to indicate that any other Blue Shield plan in the country is more efficiently operated or more widely accepted by employers, employees, and physicians than Pennsylvania Blue Shield. It notes with pride the designation of Pennsylvania Blue Shield to administer the federal employees program. It notes with pride the above average performance of Pennsylvania Blue Shield as an intermediary for the Social Security Administration in the medicare program. It notes the successful performance of Pennsylvania Blue Shield as an administrator of the in hospital portion of the medicaid program and urges the Department of Welfare to designate Pennsylvania Blue Shield as the administrator of the in office aspects of the medicaid program.

The Pennsylvania Medical Society notes that consumers play an important role on the Blue Shield Board and Blue Shield committees. The Society cites the development by Blue Shield of HMO participation, payment by diagnosis, and primary care program and its expanding dental care program as evidence of a growing, innovative insurance company providing services in the interests of both patients and physicians.

The Society does not believe that new legislation is necessary at this time for Blue Shield to successfully carry out its mission.

Abortion

The policy of the Society with regard to abortion is: Abortions should be performed only under the following circumstances (1) when there is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother; (2) when there is documented medical evidence that the infant may be born with incapacitating physical deformities or mental deficiencies; or (3) when there is documented medical evidence that continuance of the pregnancy resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of a patient; (4) when two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and (5) when the procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

Health Fraud

The Pennsylvania Medical Society is committed to fighting health quackery in whatever form it may take. To this end it has formed a committee to investigate quackery problems, to inform physicians about the problem, and finally to alert consumers to the hazards of health quackery. This committee cooperates closely with the Pennsylvania Health Council and with the Pennsylvania Department of Health. In 1973 the PMS House of Delegates authorized a Quackery Defense Fund be made up of voluntary five-dollar contributions from PMS members. By the spring of 1974 nearly $20,000 had been contributed by physicians in Pennsylvania voluntarily to fight quackery.

The Pennsylvania Medical Society notes that chiropractors are permitted to advertise. Frequently these advertisements mislead the public into believing that chiropractors can treat diseases and health problems far beyond the scope of the chiropractic licensing act. Some of these advertisements have crossed the threshold of legality and have been pursued by the Department of Justice through its Bureau of Consumer Affairs. The

Pennsylvania Medical Society is opposed to chiropractic advertising.

The Society has received reports that some chiropractors are practicing needle acupuncture. It has been determined by the State Board of Medical Education and Licensure that needle acupuncture, in which the skin is pierced, is the practice of medicine. Chiropractors therefore practice needle acupuncture illegally. The Society is determined to make the law explicit so that it will stop chiropractors from doing needle acupuncture.

The Society is aware of chiropractors who have requested that hospital laboratories accept referrals from them for blood work and that the results of the tests be returned to the chiropractors.

The Society states unequivocally that the purpose of blood tests submitted to hospital clinical laboratories is to aid a medical doctor or an osteopathic physician in making a medical diagnosis on which to base a regimen of treatment for the patient. There is no evidence that the treatment legally permitted to a chiropractor is in any way related or dependent on laboratory tests. There is presently nothing in the training, testing, or accreditation of a chiropractor to indicate the slightest qualification to interpret medical laboratory studies. To permit unqualified personnel to interpret medical data is for the Commonwealth to abrogate one of its basic responsibilities of protecting members of the public in an area in which the consumer himself does not have the training or education to protect himself.

The Pennsylvania Medical Society notes successful efforts at the national level in blocking chiropractors from providing physical examinations for truck drivers involved in interstate commerce. The Society is also aware of proposals made by chiropractors to offer free chiropractic exams to school children in certain school districts. The Society believes that were a school board to agree to such a program, it would violate the spirit and intent of the Commonwealth's regulations regarding school health examinations. The Society further points out that unless chiropractors are prepared to treat free of charge indefinitely any youngster discovered to have a problem amenable to chiropractic treatment, that such free chiropractic examination is nothing more than a new twist on the "loss leader game" and is, in fact, a very blatant patient solicitation scheme.

The Pennsylvania Medical Society serves notice that there will be no abatement in its fight to guarantee that chiropractors remain within the purview of their licensing act.

In Summary We Urge:

1. The establishment and maintenance of a strong Department of Health directed by a skilled, highly qualified Doctor of Medicine.
2. The training of more primary care physicians from Pennsylvania aided by the redistribution of residency programs across the state in areas of need.
3. Legal provision for physicians' assistants, preferably under the Medical Practice Act.
4. The adequate staffing and funding of the state Board of Medical Education and Licensure.
5. The use of Pennsylvania Blue Shield to administer the in office portion of the Medical Assistance Program.
6. The postponement of state Certificate of Need legislation until the effects of existing federal legislation become apparent.
7. The adoption of reasonable hospital licensure and uniform accounting legislation.
8. The establishment of a separate Department of Mental Health and Mental Retardation under the direction of a qualified psychiatrist or the establishment of an umbrella department concept of human services with separate and equal offices for health, welfare, and mental health.
9. The adoption of legislation calling for minimum standards for ambulance services, vehicle design, training for attendants, and equipment standards.
10. The establishment of a statewide Emergency Medical Service Council.
11. A re-evaluation of the state Civil Defense Council structure.
12. The maintenance of a strong independent Blue Shield operation.
13. A concerted effort on the part of state government to protect the citizens from health fraud.

Approved by the Board of Trustees
May 15, 1974

practice management

For higher gross income increase your overhead!

LEIF C. BECK, LL.B.
Bala Cynwyd

This month's article will present what some readers may at first think is a surprising position for an advisor to medical practices. It will suggest areas in which medical practices might properly *increase* their overhead!

One must be careful, of course, to differentiate between overhead in terms of total dollars expended and overhead as a percentage of a practice's gross income. The latter, the overhead percentage, should constantly be analyzed to determine whether it can be reduced, but often the best way to decrease it is to increase the practice's output. This output could be measured in patients effectively treated, which in turn should increase gross income.

What an appropriate overhead ratio for any single practice is must depend on the many variable factors unique to that practice's physicians and their philosophies, talents, and ambitions; but some averages may be useful as guidelines. The Society of Professional Business Consultants, to which I belong, annually collects the income and expense figures for all its members' regular clients (whose identities are obviously not revealed) and then publishes the results for its members' information and application. The results are broken down by specialties and geographical area sizes. In the last measured years, family practices' overheads averaged 42 to 44 percent of gross income. Internal medicine practices averaged around 35 percent while general surgeons' overheads typically ran 32 to 34 percent.

Practices whose overheads are far above the averages must, of course, question whether they are truly expending their moneys judiciously. In some such cases, while my survey assignment was to determine how overhead should be reduced, the problem quickly changed into increasing the gross income in relation to the expense already established. Such situations typically involve practices which have upgraded their expense levels to accommodate higher patient volumes, a goal which would not normally be criticized.

On the other hand, practices with inordinately low overhead ratios may be subject to far more criticism. A low overhead might not indicate effective medical practice management at all, for it might instead show underutilization of space, personnel, or equipment. Such sub-par use of expenses tends to reveal one or more of these basic complaints: (1) a doctor being too busy doing routine work to render really good medical care where his talents really matter; and (2) a practice shortchanging the community by not effectively treating as many patients as the physicians' efforts should permit.

My thesis, therefore, is that increasing the overhead in terms of absolute dollars will be an extremely advantageous step for some practices. The additional expenditures might lead to increased efficiency so the physicians involved may see more patients in the same amount of time and effort with equal or better clinical attention. The result of this increased efficiency should be a corresponding increase in gross income, a decrease in overhead ratio, and greater "take-home pay."

I fall far short of contending that a physician's office should be a "factory" running the maximum number of patients through its examining rooms. I feel just as strongly, however, that a physician should conscientiously treat and help as many patients as he can within the patterns of his entire life, which include his family, his civic, religious, and professional activities, his hobbies, and the like. As a result, the following description will hopefully show how increasing the number of dollars expended will improve some practices and will consequently *decrease* the overhead percentages.

Personnel

It is highly important to offer high enough salaries to attract the best possible employees. Lower salary levels are likely to attract less valuable assistance, for the old adage that "you get what you pay for" tends to be accurate. The underpaid aide is likely to have the least incentive in performing her job well and is most likely to shop

around for a better paying job opportunity. How much better it might be to increase a good aide's pay to solidify an office's employee base than to endure poor morale and high employee turnover.

Mr. Beck is President of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

Probably nothing is more costly (nor more disruptive) than employee turnover. Employees in typical secretarial, nursing, and even clerical jobs tend not to contribute effectively for three months after hire, and hence a good employee's departure is likely to cause difficulties for a period extending far beyond the date she is replaced. As a result, the economic "cost" of replacing an aide may far exceed the difference in pay necessary to retain her.

It has been said that five characteristics of a good employee can be listed in order of importance: (1) Loyalty, (2) Stability, (3) Enthusiasm, (4) Mental attitude, and (5) Technical ability. Technical ability, the aspect upon which salaries are so often based, is lowest on this list of characteristics much because it is the easiest for an employee to develop. All the other factors, said to be more important, are matters of psychology depending much upon the employee's respect for the job. Good pay certainly helps develop and retain that feeling.

Another very common failing in the area of personnel is a practice's having an insufficient *number* of aides. The result is simply not worth the money saved. I recently surveyed an office which was several months late in sending out patient bills and third party insurance forms. One person was filling the roles of receptionist, bookkeeper, and secretary; and while she was an excellent employee, the demands were simply too much for her. The practice's collections were badly suffering and the doctors' incomes were considerably below what the doctors themselves felt they were generating. In this case, hiring another aide at, perhaps $6,000 annual salary will probably return $20,000 of annual income.

Another recent survey involved an excellent specialty practice which was quite dependent upon physician referrals. The one typist in the office, however, was several months behind in typing reports to referring physicians. This fault was threatening the referral patterns and possibly the high quality of the practice itself. Hiring additional typing help was certainly an important investment in that practice.

Physicians also seem reluctant to hire adequate nursing assistance for the scheduled office hours. A practice can operate most effectively if patients are completely prepared for examination before the doctor enters the examining room. Initial histories, follow-up questioning, weighing, taking of blood samples, and untold additional tasks can quickly and easily be accomplished by an aide before the doctor actually touches the patient. Maximum time would then be made available for a doctor to deal directly with the patient's problems and to consult with the patient as needed. While this discussion may seem elementary to most readers, contrary situations arise so often that I believe the proposition must be emphasized.

Physicians' Assistants

Paramedical assistance is in its infancy, and yet it is one of the most important medical developments in many years. I am hopeful that many of my clients will use the opportunity effectively.

There are two levels of paramedical assistance. The first is simply the upgrading and improvement of

normal office aides' duties. Taking blood samples, giving routine injections, and instructing patients as to diet, well baby care and pre- and post-operative requirements are routinely handled even by aides lacking nursing degrees. These and further expanded duties can vastly improve the physician's productivity *so long as* he carefully trains his aides in those activities and maintains continuing "quality controls." An aide performing these expanded duties deserves higher pay than routine employees, recognizing the greater responsibilities involved, which expenditure should be well worth the added cost.

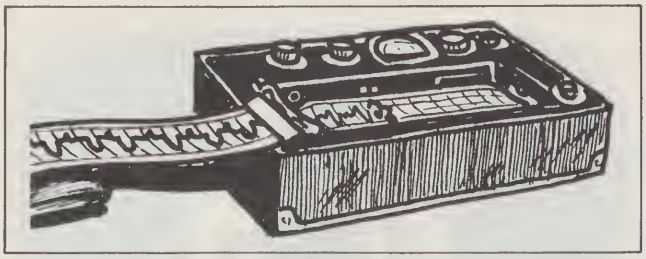
Secondly, there is the true "physician's assistant." Although Pennsylvania law is presently unresolved as to a physician's liability for his assistant's acts, with favorable legislation anticipated soon, many doctors in the state are proceeding to employ graduates of special training programs. These assistants are being assigned extensive duties in office practice; and many surgical assistants are making hospital rounds with and without the physician. The typical complaint that "my patients wouldn't accept being seen by an assistant" is not convincing, for physicians in various types of communities have "sold" it to the point of excellent reception.

In most cases, I would estimate that an absolute minimum of 30 percent of a doctor's time spent in diagnosis and treatment can actually be performed as well by a properly trained, properly supervised nonphysician assistant. To accomplish this time saving, however, the doctor must pay out a salary necessary to hire such a well-qualified assistant—an amount considerably higher than normal aides' salaries. The increased overhead is in such a case a real investment in higher output.

Any doctor developing paramedical assistance must also budget his own time to provide extensive education, supervision, and review. The assistant's effectiveness, and therefore the practice's own quality, depends so much upon this time expenditure that deliberately scheduling it is very important. It is a means of increasing the patient volume even though a doctor fails to see some patients while involved in training and/or supervising his assistant.

Office Facilities

Inadequate office space is another false economy. Reviewing a survey client's financial statement and finding office rent totalling only 2 percent of the practice's gross income, for instance, suggests the possibil-



ity of bad space utilization. The average ratio of rental expense to gross income ranges instead from 5 to 8 percent.

The most obvious example of false economy is an office with an inadequate number of examining rooms. The result is terrible loss of physician time which costs far more than additional office space. In other cases insufficient space for the business office tends to result in ineffective billing, third party insurance form and collection activities. These activities translate the physicians' work into income and do not deserve to be so subordinated to the apparent savings on rental expense.

I have urged clients to move their offices to better locations *even if* they must break existing leases at substantial penalties. Typically such moves are to buildings immediate to hospitals, thus dramatically reducing the doctors' travel and increasing their work time. In one case, three surgeons gave up nearly $10,000 in rental penalties to move adjacent to their hospital. They believe the move was the best investment they could have made.

Similarly, I typically encourage practices to enter *shorter* term leases despite the likelihood that landlords will increase the rent when the lease terms end. In my view, flexibility to move or expand an office is more important than the rental economy. Practices tend too often to take on additional doctors and/or more aides, thus outgrowing offices that had originally been considered adequate. Similarly, practices' circumstances change as the doctors might change hospital affiliations, neighborhoods might shift, etc. The ability to *change* one's office location and/or size is thus an important economy not reflected in the rental rate.

Medical Equipment

If a piece of equipment will help a doctor accomplish certain results, he should obtain it if at all possible. Yet sometimes physicians hesitate to make moderate purchases as a matter of economics. The saving may, however, be inappropriate.

A two-man OB-GYN practice I visited this past winter might present a good example. No one in the town involved had yet embarked upon performing laparoscopies, although some patients were having them performed in a neighboring city. My two clients were able and willing to perform them but were waiting for their hospital to spend about $4,000 on the necessary equipment. I encouraged my clients to go ahead and buy the equipment themselves, thus enabling them to serve their own patients and to establish their credentials in the new work ahead of others in the community. In my view, the "competitive edge" justified the expenditure.

Conclusion

These isolated stories are intended merely as examples of why spending more money may improve a practice and its finances. One must obviously be careful not to overspend, but the absolute dollars spent is not as significant as is the spending level in relation to the production level—the overhead percentage.

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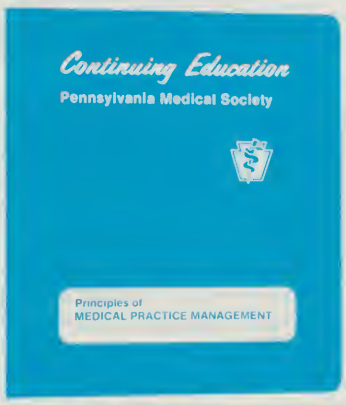

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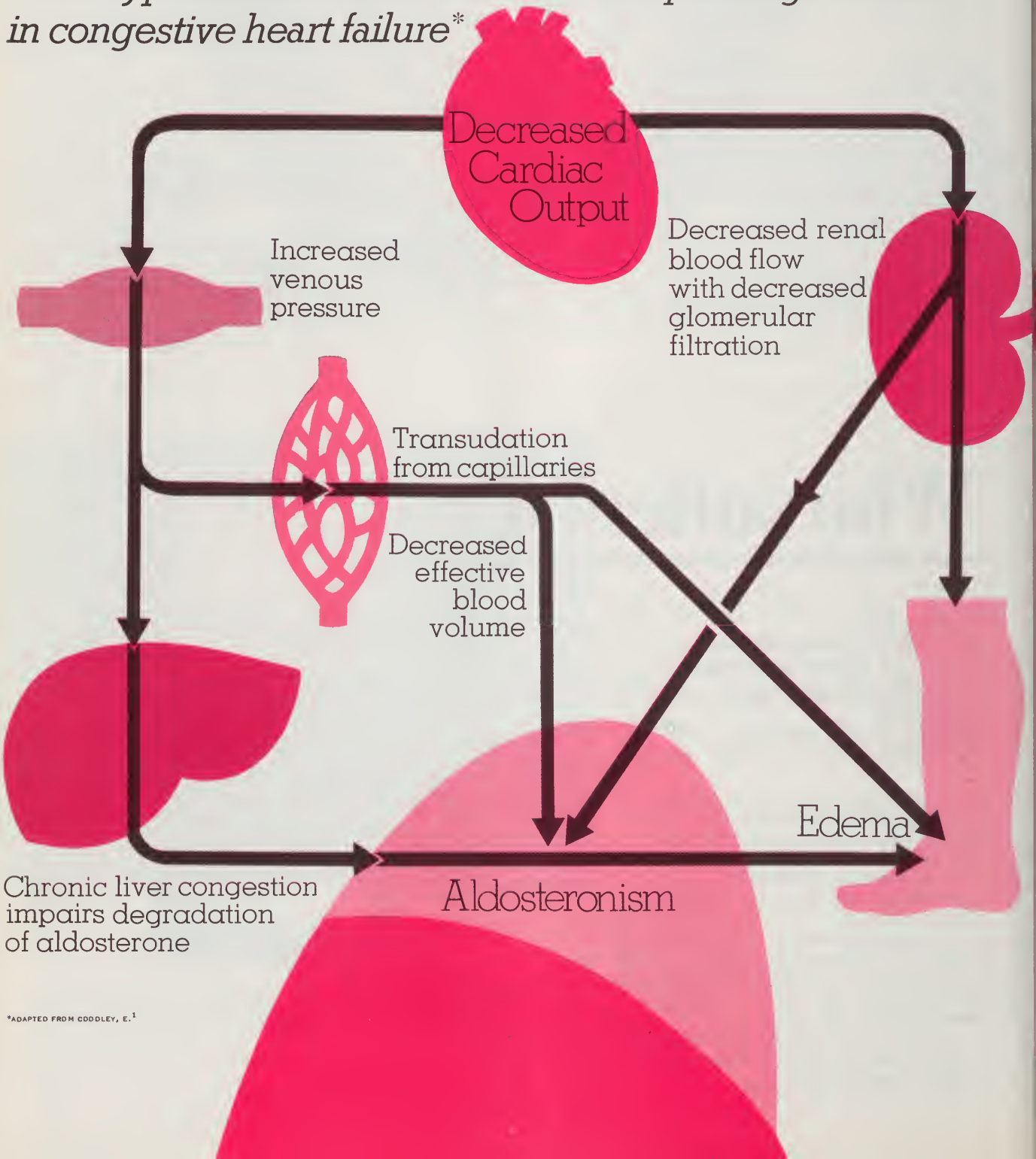

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Indications—Essentiol hypertension; edema or oscites of congestive heort foilure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edemo. Some patients with molignont effusions moy benefit from Aldoctone (spironoloctone), particularly when given with o thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impoirment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementotion may cause hyperkolemia and is not indicated unless o glucocorticoid is also given. Discontinue potossium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electralyte imbalance may occur. Although usually insignificant, hyperkalemio moy be serious when renol impoirment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethorgy and drowsiness, together with o low serum sodium may be caused or aggravated, especially when Aldoctone is combined with other diuretics. Elevotion of BUN may occur, especiolly when pretreotment hyperazotemia exists. Mild acidosis moy occur. Reduce the dosage of other ontihypertensive drugs, particularly the ganglionic blocking agents, by ot leost 50 percent when adding Aldoctone since it may potentiate their oction.

Adverse Reactions—Drowsiness, lethorgy, headoche, diorrhea and other gastrointestinal symptoms, moculopopulor or erythemotous cutoneous eruptions, urticorio, mental confusion, drug fever, otoxio, gynecomostio, inobility to achieve or maintain erection, mild ondrogenic effects, including hirsutism, irregular menses ond deepening voice. Adverse reoctions ore infrequent ond usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the doily dosage is 50 to 100 mg. in divided doses. Aldoctone moy be combined with o thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequote response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initiol daily dosoge is 100 mg. in divided doses. Continue medication for ot least five days to determine diuretic response; odd o thiozide or organic mercuriol if odequote diuretic response has not occurred. Aldoctone dosage should not be changed when other therapy is added. A doily dosage of Aldoctone considerably greoter thon 75 mg. moy be given if necessary.

A glucocorticoid, such os 15 to 20 mg. of prednisone daily, may be desirable for potients with extremely resistont edemo which does not respond odequotely to Aldoctone and o conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessory. Such potients frequently have on associated hyponatremio—restriction of fluid intoke to 1 liter per doy or administrotion of mannitol or ureo may be necessary (these measures are contraindicated in potients with uremio or severely impoired renal function). Monnitol is contraindicoted in potients with congestive heort foilure, and urea is controindicoted with o history or signs of hepotic como unless the potient is receiving antibiotics orolly to "sterilize" the gostrointestinol tract.

Glucocorticoids should probobly be given first to potients with nephrosis since Aldoctone, olthough useful for diuresis, will not directly affect the bosic pothologic process.

For **children** the doily dosoge should provide 1.5 mg. of Aldoctone per pound of body weight.

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The gastric polyp—a controversial issue

WARREN WERBITT, M.D.
RALPH M. MYERSON, M.D.
Philadelphia

THE term polyp, derived from the Greek *polypus*, was coined by Galen and Celsus in the first century and may be defined as a growth arising from a mucous membrane. Thus, polyps may originate from the upper respiratory passages, gastrointestinal tract, or genitourinary tract and may originate from any of the mucosal structures. Most polyps are adenomas, arising from glandular tissue.

Gastric polyps have been of particular interest, primarily because of the controversy concerning their relationship to malignancy and the consequent differences of opinion concerning their management.

A representative case of gastric polyps is presented, followed by a review of the topic.

Case Report

A 77-year-old woman was admitted to the hospital with severe right-sided pleuritic pain due to fractured ribs secondary to a fall. Her past medical history included diabetes mellitus, congestive heart failure, and tuberculosis. While in the hospital, the patient complained of epigastric burning, and physical examination revealed mid-epigastric tenderness. No abdominal masses were noted. An upper gastrointestinal barium study revealed lucent defects in the antral portion of the stomach suggestive of polyps. Because of these findings, gastroscopy was performed with a fiberoptic gastroscope. Four gastric polyps were seen, and one was freely movable on a long pedicle. The remaining three were sessile.

Biopsies of the polyps were consistent with adenomas of the stomach. A gastric analysis revealed hypochlorhydria. Gastric cytology showed no evidence of malignancy. Because of the patient's poor general medical condition, she was discharged to be followed by the department of gastroenterology with follow-up studies to include upper gastrointestinal barium studies and gastroscopy at a later date.

History

Lusitanus[1] in 1570 provided the first description of a gastric polyp. Morgagni[2] wrote of the postmortem findings in a case of gastric polyps in 1761. In 1857 Quain[3] made the first clinical diagnosis in a young female who vomited a piece of adenomatous tissue. Menetrier[4,5] in 1888 divided gastric polyps into two types: "polyadenome polypeux" (sessile or pedunculated polyps in atrophic gastritis) and "polyadenome en nappe" (well defined plaques with hypertrophic mucosa). Heinz[6] in 1912 was first to note gastric polyps fluoroscopically, and in 1922 Schindler,[7] using the rigid gastroscope, was the first individual to visualize a gastric polyp.

Discussion

Incidence—Gastric polyps are found equally in both sexes and are uncommon under the age of thirty. The incidence increases with age. In a total of 74,823 autopsy cases, gastric polyps were found in 0.43 percent.[8] In a series of 50,000 upper gastrointestinal barium studies, the diagnosis of gastric polyps was made in 138, an incidence of 0.28 percent.[9]

Etiology—The etiology of gastric polyps is unknown. Inflammation has been incriminated, and some investigators believe that gastric polyps are the result of chronic gastritis. Gastric polyps are closely related to pernicious anemia, achlorhydria, and atrophic gastritis.[10] They are present in approximately 5 percent of all patients with pernicious anemia. In one study of gastric polyps, 25 percent of the patients had a deficiency in intrinsic factor.

Clinical picture—Most patients with gastric polyps have no signs or symptoms. Epigastric pain is the most common complaint,[11] but a definite relationship of pain to gastric polyps is difficult to establish. Ulceration and hemorrhage is unusual. Torsion of a polyp pedicle and pyloric obstruction by a large polyp are other mechanisms by which polyps produce symptoms. Anemia is seen in approximately 25 percent of patients and is of the iron deficiency type. This may be related to occult bleeding, iron malabsorption, or decreased utilization of iron. Occasionally the anemia is megaloblastic. Achlorhydria is found in approximately 95 percent of cases.[11,12]

Roentgenographic findings—Upper gastrointestinal studies with barium are extremely important. Marschack has divided gastric polyps into three types.[9] Type 1 are sharply defined, smooth lesions, single or multiple, which are round or elliptical and with no contour defect. The polyps vary in size, are continuous with rugal folds, and a pedicle is difficult to demonstrate. These polyps are benign. Type 2 polyps are solitary, sessile, 1.5 cm to 2.5 cm in size, and demonstrate no contour defect or rigidity, but are trabeculated and irregular. Malignancy in these polyps is frequent. Type 3 polyps have contour defects with rigidity of the gastric wall and may be sessile, polypoid, and irregular. These represent carcinomas. The large majority of polyps appear as smooth defects on barium studies. Stalks may be seen with x-ray studies and Ekloff[13] and others feel that a pedicle helps to differentiate a benign from a malignant gastric polyp. Greater curvature polyps are more difficult to visualize with barium studies due to the larger rugal folds in this area, and a polyp

less than 0.5 cm will not be visualized.

Solitary polyps are more common than multiple polyps, but the ratio varies from series to series. Marschak[9] reported that most polyps are located in the pyloric channel, with the body of the stomach the second most common site.

Endoscopic findings—Gastroscopic findings are fairly characteristic. Usually, the gastric polyps are discrete, round, smooth, and either pedunculated or sessile. They may be pitted and appear strawberry-like. They may be orange in color or cherry red. Benign polyps are usually the same color as the mucosa and have well defined margins. Atrophic gastritis, with its glossy mucosal appearance and visible subcutaneous vasculature, is usually present. Malignancy is suggested with a polyp that is paler than the tissue about it, or if the polyp has a broad base and merges with adjacent tissue, or if the polyp is ulcerated. A gray tip or streaked surface markings on the polyp may indicate malignancy.[14] Ming[15] has divided polyps into those that are "regenerative" and those that are "adenomatous." The "regenerative" polyp is usually smaller than 2 cm, smooth or lobulated, may have a pedicle (29 percent), and may be multiple (31 percent). Carcinoma was seen in 8 percent of this type of polyp in his study. Microscopically, the "regenerative" polyp shows no malignant changes or anaplasia, mild to moderate hyperplasia, prominent inflammation, frequent cystic glands, marked pyloric metaplasia, absent or mild intestinal metaplasia, and the presence of muscular tissue. In contrast to this, the "adenomatous" polyp is larger than 2 cm, papillary in configuration, usually solitary with pedicles present (40 percent), and is associated with an increase in coexisting carcinoma (30 percent). Microscopically, malignant transformation occurs in 40 percent of cases, characterized by marked anaplasia, hyperplasia, and intestinal metaplasia. There is absence of muscular tissue. Pyloric metaplasia and inflammation was not prominent.

Differential diagnosis—The differential diagnosis of gastric polyps includes benign nonepithelial tumors, aberrant pancreatic tissue, polypoid postoperative defects, Menetrier's disease, tuberculosis, sarcoidosis, syphilis, amyloidosis, carcinoid tumors, lymphomas, metastatic neoplasms, and carcinomas invading the stomach from adjacent organs, particularly the pancreas. Occasionally food or blood trapped within the stomach will mimic gastric polyps. Most of the above entities are readily differentiated. Benign nonepithelial tumors present the greatest problems.

Relationship to Malignancy

As is the case with other gastrointestinal polyps, controversy exists regarding the relationship of gastric polyps to gastric malignancy. Although a relationship has been claimed by some investigators,[16] this has been disputed by others. Carey and Hay [17,18] feel that there is no relationship and that malignant degeneration of gastric polyps does not occur. Other large studies have supported Carey and Hay's work. Hay[19,20,21] has suggested that a size of 2.0 cm is critical in the determination of malignancy. Certainly, as studies have shown, size is significant, but contour defects and smoothness are also important. Berg contends that gastric polyps are precancerous and show neoplastic tendencies, while Monaco[11] states that unless the lesions are frank carcinomas, they are biologically benign, and that although atypia may be found, metastasis does not occur. Monaco feels that in a gastric polyp with a focus of atypical cells there is no submucosal or lymph node involvement. He also states that there must be a difference between the biological behavior and the histological appearance. If Castleman's work

Dr. Werbitt is an instructor in medicine and Dr. Myerson is professor of medicine at the Medical College of Pennsylvania and chief of staff at the Veterans Administration Hospital, Philadelphia. The paper was prepared by the college's gastroenterology section of the department of medicine.

with colonic polyps is applied to gastric polyps, then the prognosis is better in the presence of a stalk.[22] It becomes obvious from the contrasting points of view that much controversy still remains in the diagnosis of gastric polyps and the possible progression to malignancy. Possibly, some of this controversy arises from confusing terminology, statistics, and pathologic criteria.

Treatment—The controversy concerning the relationship of gastric polyps to malignancy necessitates an individualized approach to each patient. Certainly in the presence of clinical, radiologic, or endoscopic evidence suggestive of malignancy, surgery should be advocated. On the other hand, well-defined polyps less than 2 cm in size in an asymptomatic elderly patient with negative cytology should be handled conservatively. Polyps greater than 2 cm in size, particularly in younger patients, should be considered for surgical therapy.

Summary

Gastric polyps have been a controversial subject for many years. This article has illustrated a representative case, outlined the possible etiologies, diagnostic procedures, controversies, and management. Hopefully, with larger studies, consistent terminology and pathological criteria, and improved diagnostic procedures, more information can be gained into the histology and biological behavior of gastric polyps. □

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TRAUMA!

Initial management of injury to the neck

GARY G. NICHOLAS, M.D.
BEN M. WILLWERTH, M.D.
Hershey

The neck is a compact area of vital structures vulnerable to both blunt and penetrating injuries. Compromise of the airway or major cervical arteries will produce cerebral damage or death within minutes. Thus, the initial management of such injuries must be well-planned and executed.

The first priority for evaluation and treatment must be given to the airway. The diagnosis of airway obstruction may be obvious as in the patient who has stertorous breathing, or it may be more subtle and manifest only by restlessness or disorientation secondary to hypoxia. These effects of hypoxia may be erroneously attributed to the patient's pain or prior ingestion of alcohol. On occasion airway obstruction may be relieved by such simple maneuvers as suction aspiration of the pharynx, removal of dentures or loose teeth, or insertion of an oropharyngeal airway. If these measures prove inadequate then endotracheal intubation should be undertaken. When intubation is not possible, emergency cricothyroidotomy should be performed. This is accomplished by transversely incising the cricothyroid membrane to gain entry to the trachea. In a hypoxic hemorrhaging patient, cricothyroidotomy is technically much easier than the more standard tracheotomy.

Major vessel injury in the neck is unique in several respects. Interruption of one of the major cervical arteries is likely to result in cerebral hypoxia or infarction. An expanding hematoma in the neck, either in association with a closed injury or due to external compression to control hemorrhage may produce tracheal compression and compromise the airway. When exsanguinating hemorrhage is occuring through a neck wound, external pressure must be utilized; but close observation for maintenance of a satisfactory airway is essential. If major vessel injury is associated with disruption of the trachea, aspiration of blood may present a major

problem. In patients with this type of combined injury, immediate endotracheal intubation or cricothyroidotomy is indicated. In a patient who has sustained a closed injury of the neck resulting in hemorrhage, tracheal compression may quickly develop and once again intubation or cricothyroidotomy is indicated. In addition to these unique problems related to hemorrhage in the neck, the likelihood of hypovolemic shock must not be overlooked.

In most instances, hemorrhage from a neck wound can be temporarily controlled by the judicious application of direct pressure. Exploration of neck wounds in the emergency room is contraindicated since this may exacerbate hemorrhage and blind placement of clamps may cause serious neural damage. If the wounding agent is in place, generally it should not be removed until the patient has reached the operating room.

Following establishment of an adequate airway and temporary control of hemorrhage, at least two large-caliber intravenous lines should be placed, blood typed and crossmatched, and the patient should be transported to the operating room for definitive exploration of the neck.

When one of the larger veins in the neck is injured, air embolism is a hazard that must be considered. Placing the patient in an upright position may decrease the amount of venous hemorrhage, but it will also increase the risk of air embolism. For this reason it is recommended that these patients be transported in the supine position and hemorrhage controlled by direct external pressure.

Esophageal injuries do not generally pose any immediate threat to life. However, the onset of mediastinitis may lead to a rapid downhill course due to sepsis. When infection occurs, soft tissue swelling and fluid collections in the deep fascial compartment of the neck may cause airway compression. If airway obstruction and hemorrhage are not immediate problems, the diagnosis of esophageal injury is best made by PA and lateral films of the neck and chest combined with an esophagogram utilizing water soluble radiopaque contrast material.

Spinal cord injury is occasionally associated with penetrating neck injuries, and any evidence of neurologic deficit in the extremities should alert the physician to this possibility. Other neurologic injuries occurring in association with neck trauma are generally not life-threatening. However, their recognition and documentation are important to the subsequent care of the patient. Direct brachial plexus injuries may occur including complete avulsion of the roots of the brachial plexus. External pressure from a hematoma may also result in impaired nerve function. Injury to the hypoglossal nerve may be noted by deviation of the tongue toward the side of the injury and trauma to the accessory nerve may be recognized by a decrease in strength of the trapezius muscle on the involved side. Trauma to the vagus nerve is evidenced by a change in the voice, and on indirect or direct laryngoscopy, the vocal cord on the involved side may be paralyzed. Injury to the phrenic nerve may be diagnosed by noting a high diaphragm which is immobile on physical examination. This can be further documented by fluoroscopy of the involved diaphragm.

In summary, the initial management of neck trauma should consist primarily of establishment of an adequate airway and the control of hemorrhage along with replacement of blood volume. A minimum mortality for this type of injury can best be obtained by surgical exploration of all penetrating neck injuries and any blunt injury in which clinical examination indicates disruption of any of the major structures lying deep to the platysma muscle. □

The authors are from the department of surgery, the Milton S. Hershey Medical Center, Pennsylvania State University. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

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Significance of visual problems in Pennsylvania drivers

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CRASH analysis by the Pennsylvania Department of Transportation for the calendar year 1971 indicates 81,696 crashes causing 667 deaths, 1,604 bodily injuries, and 59, 984 cases of property damage in this state. Alcohol was the largest identifiable causative factor among the fatalities (318 out of 667), and it related to 5,915 crashes which caused bodily injury or property damage. Visual factors had prime causative identification in 72 deaths, 1,604 bodily injuries, and 3,639 cases of property damage. Such efforts to identify causative data underline revised visibility (FMVSS 111) and illuminating (FMVSS 108) standards which the National Highway Traffic Safety Administration was seeking to put into effect in 1973.

Physical Examination Program

Required physical and visual examination of Pennsylvania drivers was instituted in June 1960, with random re-examination beginning in November 1960. There now are approximately eight million licensed Pennsylvania operators, and initial efforts at hand-recording of data became so overwhelming that the project was temporarily discontinued from March 1964 until electronic data processing was instituted in August 1965. By the end of 1971, approximately three million prelicensing physical examinations were administered. Of that number 4,143, (0.137 percent) were denied Pennsylvania licenses for medical reasons.

Under the first re-examination program (November 1960—March 1964) for persons holding Pennsylvania licenses, there were 806,918 drivers examined, and of this number 30,131 (3.7 percent) had their licenses suspended for medical reasons. With the reinstitution of the physical examination program in August 1965 (which continued through July 1972) 1,508,610 more drivers were examined; and from this collective 2,375,528, an additional 33,522 or a total of 63,653 (nearly 2.7 percent) have been suspended for medical reasons. This percentage of pathology detection is about twenty times greater than the abnomal findings on prelicense examination. During these two periods, 16,207 operators voluntarily surrendered their licenses; nearly 5,000 were found to be deceased; and nearly 10,000 examination notices were returned "unclaimed."

The physical examination for visual acuity has resulted in Bureau notifications to slightly over a half million operators (579,597) or about 10 percent of all examinees. Restrictions to daylight driving only were placed on 3,004 drivers on the basis of (1) ophthalmic reports indicating poor night vision, or (2) limitation of optimally corrected vision at the level of 20/50 to 20/60 using both eyes together. An additional 50,333 drivers have been required to add outside mirrors because of (1) vision correctable to no better than 20/100 in one eye, or (2) gross hearing deficiency (inability to distinguish normal conversation ten feet to the rear of the candidate). The eleven-member Medical Advisory Board, including one ophthalmologist and one optometrist, recommended horizontal form field requirements of 140° in 1970. This can be met by the one-eyed driver, but because of man hour and cost requirements, it has not yet been implemented.

Most of the actions taken thus far have been the specific result of the driver re-examination program, pri-

'Pennsylvania has made major and pioneer efforts in visual and physical screening of its 8 million drivers. Re-examination programs apparently detect pathology which may constitute driver limitation about twenty times more frequently than do pre-examination programs.'

marily since its initial computerization in August 1965. Without this program, most such deficiency would have continued to pass unnoticed. Of the 33,522 (or 2.22 percent of 1,508,630) who have had driving privileges cancelled for medical reasons since August of 1965, there were 1,269 rejected for visual defects. Neuropsychiatric disorders were the most common medical cause for suspension, accounting for approximately seven times more rejections than poor vision. The role of aging as it affects this group of Pennsylvania drivers (including visual problems) was evaluated recently by Freeman[1] using strong support for performance ability rather than age per se as the basis for identifying driver limitation.

Because of the examination program, about 50,000 operators a year are advised of visual deficiency, so that a public health measure is an incidental component of the program. Drivers failing the visual examination, as well as those passing the minimal standard of the 20/40 but showing less than 20/20 with correction, are advised to have ophthalmic follow-up care and may be required to submit periodic medical reports from their eye physician to indicate that vision is not progressively failing.[2,3]

The 20/40 level of minimal acuity is selected because the lettering on freeway contol signs is sized to be read by a driver with acuity of at least 20/40. Additionally, the engineering of these signs takes into account the need to read them at usual traffic speeds on clear days—and sufficiently early to make appropriate vehicular maneuvers.[3,4]

Although Pennsylvania has maintained only one classification of driver licensure rather than the three proposed by the American Medical Association,[2] the Royal Board of Health in Great Britain, the U.S. Department of Transportation, and the U.S. Public Health Service,[5] new standards were placed into effect at the end of 1970 for the 11,000 to 12,000 school bus drivers of the Commonwealth. The Medical Advisory Board to the Department of Transportation is currently working on the third revision of these standards which should be considered as "Class 1." At present, however, the maximum central acuity requirement is only correctable vision to 20/40 in the better eye and no worse than 20/50 in the fellow eye. A school bus driver also must have a form field or horizontal recognition field of not less than 160° with both eyes open. Further, he must be able to distinguish traffic control colors of red, green, and amber and be able to "exercise distance judgment in the driving task." This more liberal interpretation has replaced earlier plans specifying Keystone telebinocular types of stereopsis measure, or tests of "space perception."

Data currently computerized for Pennsylvania licensed drivers afford some correlation between visual acuity, monocularity, and crash or violation records. Among Pennsylvania drivers operating with visual restrictions, 15 percent have crash records at this time. This figure seems higher than had been anticipated in the licensed driving population of the Commonwealth.

Other Validation Approaches

Paired studies matching control groups against drivers having systemic disease associated with eye defects.—Campbell and Ellis[6] in a five and a half year study of 346 diabetic drivers within Prince Edward Island Province (Canada) matched them by age with nondiabetic drivers and found nearly twice as many crashes and more than twice as many major convictions among the diabetics. Though vision was not reported in this study, which included licensed drivers throughout the entire driving age, their sampling showed a greater than linear increase in numbers of subjects throughout successive pentades of life. Inherently, both impairments of acuity and mesopic visual function must be overrepresented among their diabetics.

Autopsy study of eyes and visual pathways following crash deaths—These can correlate the side of visual loss with the direction of lethal impact. This "after the fact" tech-

nique has been reported by Freytag and Sachs[7] of the Medical Examiner's Office in Baltimore who studied ocular and visual pathway defects in five pedestrians and two drivers killed in Maryland. Necropsy findings of lesions, which would have been manifested by poor vision to one side, showed specific correlation with carefully reconstructed directions of injury. Such autopsy findings, though not reflecting rate or incidence data, support the limitation created by visual field impairment or monocularity.

Case records of surviving drivers referred to medical advisory boards.—Significant numbers of such drivers ultimately coming to the Medical Advisory Board of Pennsylvania recurrently illustrate successions of injuries, property damages, and fatalities in crash experience associated with monocularity or visual field impairment.[8]

Studies of monocularity versus binocularity in paired groups.—My report of 1968[9] identified monocularity in 8 percent of 991 drivers called in for a medical review following multiple crash histories. In a "control group" of 21,000 private patients seen in my office for eye care, 423 or only 2 percent had monocular blindness. Thus monocularity seemed to be overrepresented by a factor of four in this sample of crashing drivers.

Studies of driver performance on the road with subsequent identification of the visually normal and visually limited drivers.—Liesmaa reported in 1973[10] road observation of 1,021 drivers for three types of driving errors and then performed roadside examination of visual function with Rodenstock equipment on each one. Driving errors studied were (1) overtaking when another vehicle is approaching, (2) crossing the lane divider or overtaking on a curve, and (3) carelessly entering major roads. One hundred sixty-seven drivers were identified as involved in these three classes of errors, and 854 other drivers constituted control material. Among those overtaking when another vehicle is approaching, there were 20 percent who showed significantly impaired acuity and only 6.4 percent with impaired acuity in the control group. No visual difference could be identified among sixty-four drivers involved in carelessly crossing the lane divider. However, among twenty-five drivers showing dangerous entrance to major roads, 12 to 48 percent (depending on criteria) had visual limitation—two were blind in one eye, one had major visual loss, and nine had slightly decreased visual acuity (below the level of 20/30). In general, slightly decreased visual acuity did not correlate with the three identified types of inappropriate driving.

Summary

Pennsylvania has made major and pioneer efforts in visual and physical screening of its 8 million drivers. Re-examination programs apparently detect pathology which may constitute driver limitation about twenty times more frequently than do pre-examination programs. Screening in Pennsylvania produces an incidental public health service in noting apparent visual deficiencies in approximately 50,000 drivers a year. The program also creates an atmosphere in which the driver, recognizing his own inability to perform, may surrender his license. The activity also serves to update the roles of those licensed in Pennsylvania. Computerized information concerning medical factors and crash records is beginning to produce correlations between driver limitations and road behaviour. Approximately 15 percent of all drivers operating with visual restrictions now have crash records. It also appears that one-eyed or monocular drivers also engender greater risks of driving failure from the impaired side.

Special classifications of drivers are recommended medically with identification of school bus, emergency vehicle, and commercial passenger drivers meriting the best in physical performance and the most intensive level of medical screening. Limited data derived from analysis of computer output can be augmented by paired medical studies, matching controlled group drivers against others with systemic diseases which produce associated eye defects. Autopsy of deceased drivers and vehicles, as well as individual case studies of drivers and driver performance, augment these conclusions. □

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Case report

Thyroid crisis following abdominal surgery

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A RARE case of thyroid crisis which followed intestinal resection is presented. Hyperthroidism was not recognized prior to surgery, and the crisis was diagnosed several hours after the operation. The main manifestations were fever, tachycardia, and restlessness. The condition was successfully treated with propanolol and antithyroid drugs. The possible mechanisms for the development of the crisis and the role of antithyroid drugs, catecholamine depleting, and beta adrenergic blocking agents are discussed.

Thyroid crisis is an exaggeration of the manifestations of hyperthyroidism.[1] This serious condition requires prompt recognition and effective treatment if the patient's life is to be saved. Previously it was an infrequent complication of thyroidectomy for hyperthyroidism. Presently, because of the better preoperative control of the hyperthyroid state, it is rarely seen after thyroidectomy. However, it may be encountered in nonsurgical illnesses or may complicate extrathyroid surgery. The occurrence in patients with undiagnosed hyperthyroidism is extremely rare.[2]

Case Report

A 35-year-old housewife was admitted to the hospital with a history of sudden severe abdominal pain. The pain was continuous, associated with frequent vomiting, and localized in the area of the umbilicus. The patient stated that she had lost eighteen pounds over the last year in spite of having had a good apetite. She had a past history of appendectomy and fibromyomectomy, and had been treated for primary sterility. Her menstrual periods had been regular, but her last period was ten days late.

Physical examination at the time of admission revealed a well-nourished female in severe pain. Her pulse rate was 120 per minute, temperature 36.5° C., and blood pressure 160/90 mm.Hg. Examination of the head, neck, heart, and chest did not reveal any abnormality. Examination of the abdomen showed a lax abdominal wall and suprapubic tenderness. Radiologic examination of the abdomen was equivocal. The patient was treated with intravenous fluids and nasogastric suction and observed carefully. When re-examined later, an ill-defined irregular mass was felt in the lower abdomen. This was extremely tender, and there was rebound tenderness. Vaginal examination revealed pelvic tenderness, and some blood was seen on the examining finger.

The clinical differential diagnosis was between complicated ectopic pregnancy and intestinal strangulation. Exploratory laparotomy was performed. At operation, a loop of ilium was found to be strangulated by an adhesive band, and nearly one foot of intestine was nonviable. Resection with end-to-end anastomosis of the small bowel was performed.

In the immediate postoperative period, the pulse rose to 170 per minute and the temperature to 40.1° C. At the same time she became restless and delerious. Sparine® (Wyeth Labs.) 50 mgm was given intramuscularly, and ice packs were applied on her limbs. Her pulse continued to rise, and the patient did not respond to treatment of symptoms. The possibility of thyrotoxic crisis was considered. The history of weight loss despite good apetite supported the diagnosis. Re-examination of her neck showed a slightly enlarged thyroid gland, and a bruit could be auscultated.

Propanolol hydrochloride, 20 mgm, was given three times daily together with Valium® (Roche Labs.), 5 mgm, three times a day. A blood sample was taken for thyroid function studies. The patient showed improvement and methimozole 15 mgm three times a day was begun. On the second postoperative day her pulse rate was 110 per minute, and her temperature was 37° C. She was calm and quiet. Her bowels moved forty-eight hours after surgery, and her abdomen was soft. On the third day her pulse dropped to 80 per minute and continued to be stable to the time of her discharge from the hospital. The results of thyroid hormones estimation was protein-bound iodine 20 ug/100 cc, T_3 uptake ration 1.88, and free thyroxin index 37.6.

The patient was advised to continue on reducing doses of methimazole and was discharged on the fourteenth postoperative day in good condition. On an outpatient visit, she was well controlled, free of symptoms, and taking methimazole only.

Discussion

Ransom in 1934[3] reported thirty-seven fatal cases of thyroid crisis occurring within a six-year period. The incidence of this condition has dropped markedly to the extent that single cases are now reported in the literature. In addition, more cases of spontaneous thyroid storm without surgical trauma are now being seen.[4]

Thyroid crisis appears almost exclusively in patients who had been thyrotoxic before the onset of

the storm.[5] In these cases thyroid crisis may be precipitated by administration of therapeutic doses of radioactive iodine.[6] It also has been reported after excessive ingestion of thyroid hormone.[7] Other precipitating factors may include: thyroid or extrathyroid surgery, infection, pre-eclampsia, delivery, fear, anxiety, and palpation of the thyroid gland. Insulin reaction, pulmonary embolism, other stressful conditions, and withdrawal of antithyroid drugs have also been blamed.[8]

The mechanism of thyroid storm is not completely understood. However, two possible mechanisms to explain the pathogenesis have been advocated. The first hypothesis is based on the possibility of excessive release of thyroid hormone by the gland. This is applicable to patients who develop thyroid storms after radioactive iodine therapy.[6] It is assumed that I_{131} causes necrosis of the thyroid follicles resulting in an acute release of the stored hormone into the circulation and in quantities large enough to cause thyroid crisis. If one assumes an unusual sensitivity of the peripheral tissues to the action of the circulating hormone, then the above explanation is likely. Corroborating evidence includes the effective reduction in the incidence of crisis among patients who have been treated with antithyroid drugs. In these patients, the follicular contents of the thyroglobulin is markedly reduced, and therefore the chance of sudden release into the circulation of excessive hormone is unlikely.[6]

The short time interval between surgery and the onset of the crisis leads us to speculate on the possibility that anesthesia might have played a role in precipitating the condition. It is known that some anesthetic agents such as halothane and ether may considerably increase the total thyroxin level in the blood.[2] On the other hand documentation of elevated protein bound iodine or T_3 or thyroxin during the crisis has not been commonly shown. Moderately raised blood hormone levels have always been noticed.[9]

The second possible mechanism considers thyroid storm as an acute adrenergic outburst, greatly sensitized by the thyroid hormone.[10] The similarities between the hyperdynamic state of the cardiovascular system in hyperthyoidism and that seen after excessive dosage of epinephrine has contributed to the idea that many circulatory and other manifestations of thyroid storm represent augmented response to adrenergic stimuli, to which the hyperthyroid patient is particularly sensitive. The amelioration of symptoms that occur after the administration of drugs which deplete catecholamine stores, impair release of adrenergic neurotransmitter, and of propanolol (which blocks the beta adrenergic receptors) support the hypothesis that none of these drugs affect the thyroid function.[11] On the other hand, it would appear that epinephrine or norepinephrine are not totally responsible for the clinical manifestations of thyrotoxicosis. There is no convincing evidence showing that catecholamines are elevated or that their destruction is delayed. This may lead to the conclusion that this condition is in reality the result of both adrenergic stimulation and end organ sensitization mediated through thyroid hormone. Interruption of these pathways either by antithyroid drugs or by antiadrenergic agents will definitely ameliorate the manifestations. Consequently, in managing a patient who is in a crisis, treatment should be directed toward the following objectives: Prevent further formation and release of thyroid hormones, prevent release of catecholamines and/or block their sites of action, then give symptomatic treatment.

Suppression of thyroid function can be achieved by antithyroid drugs. Iodine in pharmacological doses will result in large uptake by the thyroid gland and inhibition of the organic binding of iodine and tyrosine, so that thyroxine synthesis cannot proceed. At the same time, iodine inhibits the release of thyroid hormones. The exact mechanism of this action is unknown, but it is believed to be due to inhibition of release of thyrotropic hormone.[12]

'Thyroid crisis is an exaggeration of the manifestations of hyperthyroidism . . . Thyroid crisis appears almost exclusively in patients who had been thyrotoxic before the onset of the storm.'

These effects are temporary and last for two to four weeks. Only then will the escape phenomena be noticed.

Other antithyroid drugs are known to function either by preventing the trapping mechanism of iodine or by inhibiting hormone synthesis in the gland through inhibition of the necessary enzymes. These drugs may be given at the same time as iodine.

The drugs which stop the effect of epinephrine and norepinephrine include reserpine. This is known to have a central and peripheral depleting effect on catecholamine stores.[13] Furthermore, guanethidine depletes not only the peripheral stores, but it also inhibits the discharge of postganglionic adrenergic transmitters.[14] These two catecholamine depleting agents have recently been used in the treatment of thyrotoxic crisis.[15] Reserpine in addition readjusts the thermoregulatory mechanism which is usually overcome by excessive heat production during the crisis. Dillon et al[15] showed that the patient's hyperthermia in these cases responded rapidly to reserpine. The high level of free fatty acids reported by Buckle[16] suggests excessive lipolytic activity in these patients; and damping of the accelerated metabolic activity, in response to reduction of the tissue catecholamine level, also results in rapid reduction in the elevated free fatty acids. However, side-effects of reserpine should be considered. These may include diarrhea, parkinsonian tremors, conjunctival injection, weakness, dizziness, and nervousness. Carcinoid-like syndrome was also described following reserpine administration.[17]

The beta adrenergic blocking compound (propanolol), has been used with increasing frequency and success in the treatment of thyroid storm.[18,19] Weiner and his colleagues[20] used propanolol and concluded that it attenuated the effect of thyroid hormone on the heart and probably depressed the exaggerated myocardial requirements of oxygen. Levy and Epsein[21] further indicated the presence of two separate adenyl catalase systems in the heart, and these are influenced by beta adrenergic blocking agents and are activated by epinephrine, while the other is not affected by these agents and is activated by thyroxine. Propanolol was also found to be of value in the treatment of hyperthyroid patients during their preparation for surgery[22] or after I_{131} therapy to achieve rapid control of the manifestations until the effect of the radioactive iodine is clinically apparent.

Hedge[8] believes that there is a relative deficiency of circulating cortisone during thyroid crisis. One study has demonstrated a slightly lowered level of cortisone.[11] Steroids were also found to inhibit thyroid hormone release, produce antipyretic effect, and suppress the long-acting thyroid stimulator which is responsible for hyperthyroidism in Grave's disease. Its use for the later purpose is rational.

Other treatment should include bed rest and maintenance of hydration and electrolyte balance. Central venous pressure monitoring is advisable to prevent heart failure. Also required are adequate nourishment, treatment of infections with antibiotics, symptomatic control of fever with salicylates, and treatment of heart failure with digitalis and diuretics. Appropriate management of hypoxia, diarrhea, or acute renal failure is also indicated.

After prompt control of thyroid crisis, attention should be directed to producing an euthyroid state by definitive treatment of the hyperthyroidism. □

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In western Pennsylvania

Students approach the medical manpower problem

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The Western Pennsylvania Health Preceptorship Program is a student-directed educational experience in primary care and community health which appears to have succeeded in meeting certain educational objectives. It is as yet unknown whether the program will have an impact on physician specialty and geographic areas of practice in Pennsylvania. There are some indications that it may. The program represents an approach, designed by medical students, to the problem of physician maldistribution by specialty and location. Sixty students are involved in this learning experience in the 1974 program under the sponsorship of thirty-two community hospitals and clinics and two county medical societies.

FOR THE last four years, the Western Pennsylvania Health Preceptorship has provided an experience in primary care medicine and community health for freshman and sophomore medical students. During that time, 191 students have spent their summer vacations studying under the direction of practicing physicians in many communities of western Pennsylvania. The program in 1973 was the largest, placing seventy-three students at thirty-nine community hospitals and clinics.

The planners of the program recognized the need for more primary care physicians in many communities of Pennsylvania, and one of the long-range objectives has been to influence medical students towards a career choice of primary care medicine.

Program Description

The Western Pennsylvania Health Preceptorship is an extracurricular program organized and directed by a planning committee of students at the University of Pittsburgh School of Medicine, faculty of the department of community medicine, and physicians in private practice in western Pennsylvania. Program administrative costs are met through grants from the Allegheny County Medical Society Foundation, the Cambria County Medical Society, and the department of community medicine. The planning committee sets the objectives of the program as an educational experience. The objectives for 1973 were to:

1. Observe, experience, and better understand: (a) health care delivery in the community in comparison with the University Medical Center; (b) the concept of comprehensive health care; (c) the economic, cultural, political, and environmental determinants of health in a community; (d) the role of the primary care physician in the present health care system; (e) the expectations and viewpoints of patients and communities regarding health care.
2. Correlate basic science and clinical problems through patient contact.
3. Enable students to better plan their medical education and career goals.

Any medical student who had completed at least one year of training at any medical school was eligible to apply for a position. Applicants submitted written statements which indicated their educational expectations and special interests for the summer. Preceptors were practicing physicians, usually primary care physicians (family physicians, internists, or pediatricians), who volunteered to instruct a student for eight weeks in the summer. The preceptors were all affiliated with community hospitals or group practice clinics which served as sponsoring institutions. Each participating student was provided with room, board, and a stipend of $600 by the sponsoring institution or its medical staff.

Program Operation—1973

As in previous years, preceptors, sponsors, and students were recruited by the planning committee during the fall and winter months. In the spring the student applicants were matched with preceptors and communities in an attempt to provide maximum educational value for each student.

Students were oriented to the goals of the program through a series of meetings directed by planning committee members. During these meetings the students were given information about the hospitals, communities, and areas in which they were placed and were given survey forms to help them systematically study health care in their community. Students who had had no prior clinical exposure were introduced to the fundamentals

Dr. Skinner, former chairman of the Planning Committee of the Western Pennsylvania Health Preceptorship Program, received his medical degree in May from the University of Pittsburgh School of Medicine. Mr. Nevin served as project director for the 1973 program and is now chairman of the Planning Committee. He will be a fourth year student at the School of Medicine. Mr. Carlini, who will be a third year student, served as evaluations chairman for 1973.

of office diagnostic procedures (e.g. determination of vital signs, auscultation of the chest, venipuncture, ophthalmoscopy, urinalysis, throat culture) at a meeting held at St. Margaret's Memorial Hospital. The techniques were demonstrated by the family practice staff of St. Margaret's, and the students practiced on one another. The final orientation took place at the school of medicine on the first day of the program.

Each preceptor was sent a copy of the program goals and a suggested list of guidelines for the summer. Physicians who had participated in the past received specific suggestions for improvement of their programs. Each preceptor was given some background information about his student(s). The students and their preceptors constructed individual programs to best achieve the program goals based upon the special interests of the participants and the characteristics of the community in which the experience took place.

The program lasted from June 25 to August 17. A student member of the planning committee served as project director and was assisted by six area coordinators who were student participants in the program. Students kept in touch with the project director through written reports, and each program was visited by the project director and area coordinators.

The experiences of the students varied according to the interests of the student, the interests of the preceptors, and the resources and problems of the community. All of the students were exposed to the health care delivery system as it functioned in the community. They observed office practice and the management of the physicians office, learned about methods of payment for health services, observed the organization and management of the community hospital, attended staff meetings, and visited health care agencies and facilities within the community. The clinical experience of the student depended in part on his prior level of education (i.e. post freshman or post sophomore). Most students went on house calls, took night and weekend call, went on hospital rounds, and scrubbed in the operating and delivery rooms. The community exposure was dependent on the nature of the community. Most students visited community mental health facilities, public health departments, ambulance services, and the health facilities of industrial plants. When possible, students made home visits with visiting nurses. The area coordinators arranged visits for students in their areas to institutions such as the Western State School and Hospital, Warren State Hospital, Harmarville Rehabilitation Center, the Visiting Nurses Association, and Westinghouse Electric Company.

Each participating student completed an evaluation questionnaire both before and after the summer experience. The questionnaire was designed to rate the student's achievement of program goals, assess his career plans, and elicit comments about his particular preceptorship experience. The preceptors, hospital administrators, area coordinators, and project director likewise evaluated each student. Each observer rated the achievement of each program goal on a numerical scale. For each student and each goal, the total score of all raters was reported as a percentage of the maximum score which could have been obtained. An average of the scores of all students for each goal was calculated. Mean goal achievement for the whole program ranged from 76 to 88 percent of maximum. In addition each student was placed in a goal achievement category according to his score; 0-59 percent = poor, 60-79 percent = adequate, 80-89 percent = good, and 90-100 percent = excellent (Table I).

Opinions of participants about the program also were elicited as part of the evaluation. All but one student considered the program to be a valuable educational experience. A total of 97 percent of the preceptors thought that the program had a high educational value, and all agreed that the program should be continued. A total of 94 percent of the hospital administrators reported that the program was effective in teaching students about the workings of the community hospital, and over 80 percent believed that it aided in attracting physicians to their communities.

An Approach to Physician Distribution

A major objective of the planners of the Western Pennsylvania Health Preceptorship Program was to favorably affect the problem of physician distribution with respect to specialty and geographic area of practice. Many communities are underserved by primary care physicians, and some communities have no physicians at all. Many approaches to this problem have been proposed. Many involve loan forgiveness in return for guarantee to practice in underserved areas. Some communities have guaranteed income and professional facilities to physicians willing to practice in their community. Financial coercion has been proposed in the form of obligation of graduated medical students to pay back the amount of state subsidy of their education if they do not practice a required number of years in designated underserved areas.

The planners of the Health Preceptorship Program believed that educational exposure to the realities of primary care practice would be more effective than financial incentive or coercion.

The Western Pennsylvania Health Preceptorship Program enables a medical student early in his career to experience first-hand the opportunities, advantages, and problems of primary care practice outside the University Health Center. The preceptorship is, above all, an educational experience. It provides the student with an exposure to primary care, just as the curricular rotations in pediatrics, psychiatry, surgery, etc. provide the student with exposure to those fields. It is very difficult for a young physician to choose a career in a field to which he has had no educational exposure. The student is provided with a role model of a practicing physician of a type that he does not see in a university center. Participation in the program gives the student some concrete experience on which to base his ultimate career goals. It is thought that after this experience, some students will elect a primary care career rather than one in other specialties. Some students also will find

TABLE 1

Distribution of Students In 1973 Program Evaluated for Goal Achievement

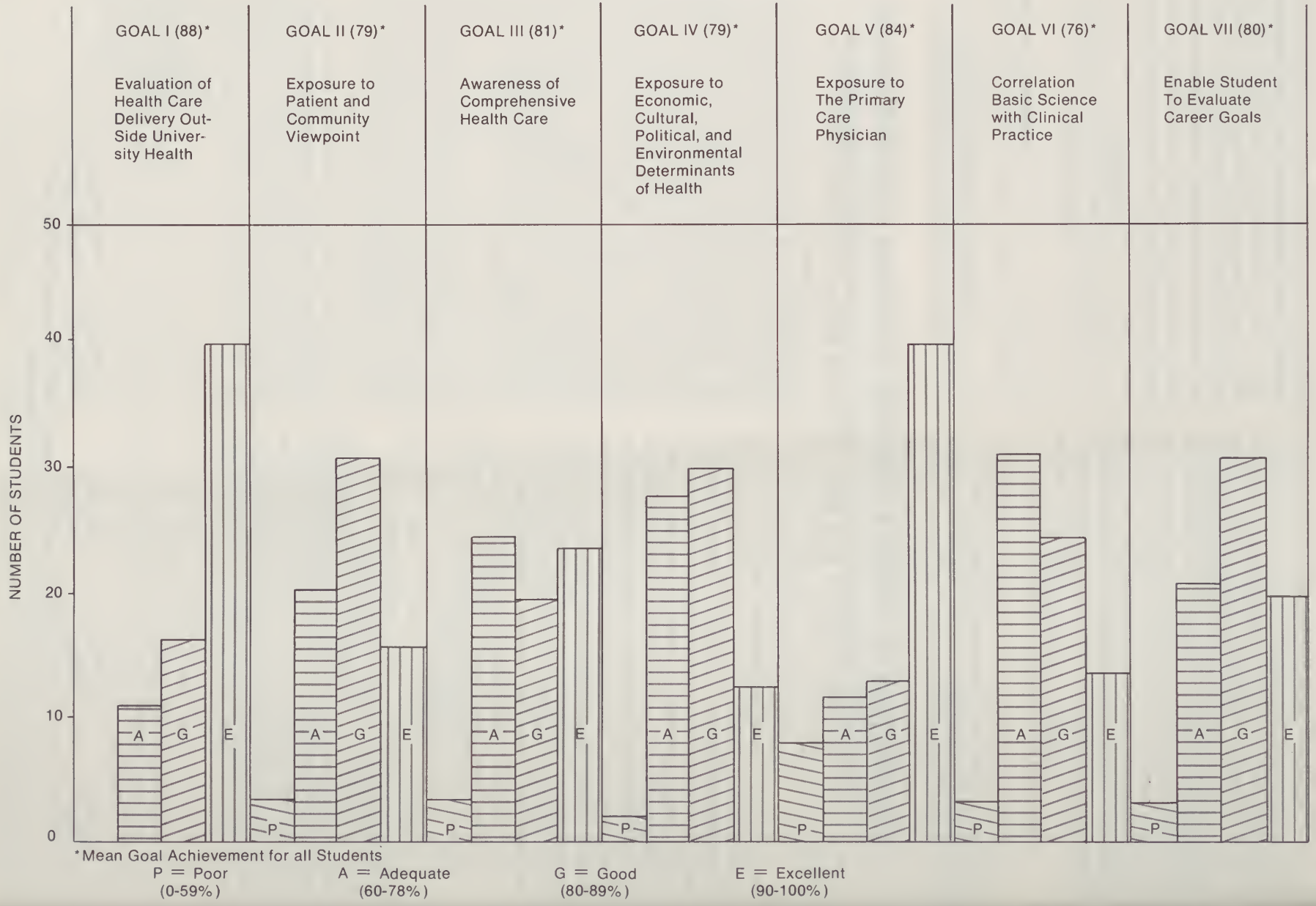

TABLE II
Internship Choices
University of Pittsburgh School of Medicine Graduates 1972-1974

	Family Practice		Pediatrics		Medicine		Surgery		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%
Participants in Preceptorship Program N = 63	9	14	8	13	27	42	8	13	11	18
Non-Participants in Preceptorship Program N = 265	2	1	29	11	99	37	43	16	92	35

the quality of life and style of practice outside the specialty-oriented health center attractive. It also is expected that some students who plan a career in primary care will be disappointed by what they experience in the preceptorship program. This, too, is beneficial since a student has something more than fantasy to guide him in his career choice and perhaps can avoid a regrettable decision. Whatever his ultimate career choice, any student who participates in the program will have a more complete appreciation for the role of the primary care physician as a result of his participation.

Over the last three years, sixty-three former participants in the Western Pennsylvania Health Preceptorship Program have graduated from the University of Pittsburgh School of Medicine. Of these, eight have completed internship, twenty will finish internship this year, and thirty-five will begin internship in July. Although it is too early to know where and in what specialty these physicians will practice, choices of internships may be regarded as an indicator of future career plans. The internship choices of participants, as well as those of their nonparticipating classmates, are presented in Table II. Analysis of the internship choices of the two groups reveals only one difference. More of the former participants have gone from medical school into residencies in family practice than would be expected if there were no difference between them and their classmates (X^2, 1 df, $p \lesssim .001$). For all other types of internship, there is no statistically significant difference between participants in the program and their nonparticipating classmates.

There are several circumstances which may account for these observations. First, the number of physicians entering family practice residencies nationwide has increased dramatically in the last three years. Second, students who elected the preceptorship program likely differed in interests, values, and goals fom other students even before they entered the program.

It is not possible, therefore, to identify the influence, if any, which the Western Pennsylvania Health Preceptorship Program has had in causing the increase in the number of University of Pittsburgh graduates electing careers in family practice or primary care medicine. It is too early to determine whether the communities of Pennsylvania will benefit from the availability of more primary care physicians as a result of the program. It is the opinion of the planners of the program that participating students have had a meaningful educational experience which has led to a more complete understanding of primary care and has been of value to them in choosing specific careers in medicine. □

Supplemental Call to the 1974 Annual Session Pennsylvania Medical Society House of Delegates

Proposed Amendments to the Constitution and Bylaws

Material underlined is being added. Material in brackets is being deleted.

Subject Eight
The Election of District Councilors by District Constitution

These amendments were considered by the House of Delegates at its 1973 meeting. The Reference Committee on Constitution and Bylaws recommended that this amendment not be adopted. The House re-referred consideration of this subject to the Committee on Constitution and Bylaws for reconsideration and resubmittal to the House. At its 1974 meeting, the Committee on Constitution and Bylaws reviewed these amendments and recommends that no change be made in the method of electing District Trustees. This amendment is reintroduced because the charge to the Committee on Constitution and Bylaws was to review and resubmit.

Article VIII - Board of Trustees and Councilors

Section 3. Election

The Trustee and Councilor from each Councilor District shall be nominated by the voting members in the House of Delegates from the Councilor District which the Trustee and Councilor is to represent, and shall be elected by all the voting members in the House of Delegates from the Councilor District which the Trustee and Councilor is to represent present at the Annual Session of the House of Delegates at the expiration of the term of the Trustee and Councilor from that Councilor District. . .

(Secretary's Note: Two-thirds vote required.)

Alternate amendment for the election of District Councilors by district including ratification by the House of Delegates as offered by the Committee on Constitution and Bylaws.

Section 3. Election. The Trustee and Councilor from each Councilor District shall be nominated by the voting members in the House of Delegates from the Councilor District which the Trustee and Councilor is to represent, and shall be elected by all the voting members in the House of Delegates from the Councilor District which the Trustee and Councilor is to represent present at the Annual Session of the House of Delegates at the expiration of the term of the Trustee and Councilor from that Councilor District. Such election by Councilor District shall not be considered final until ratified by a majority vote of the House of Delegates. . .

(Secretary's Note: Two-thirds vote required.)

Subject Nine
Continuing Education

At its meeting of March 13, 1974, the Board of Trustees and Councilors reviewed a request from the Council on Education and Science that the Constitution and Bylaws be reviewed to make certain that no member actively providing medical care could avoid the requirement of continuing medical education. At its 1974 meeting, the Committee on Constitution and Bylaws made such a review and prepared the following Constitutional and Bylaws changes so that any member providing medical care must meet the continuing education requirement.

Constitution
Article IV-Membership

Section 12. Continuing Medical Education Requirement—In order for an Active or Senior Active dues-paying or Associate Member of this Society to remain a member in good standing of the Society after December 31, 1975, he must show evidence of engaging in continuing medical education as prescribed by the Bylaws of this Society.

(Secretary's Note: Two-thirds vote required.)

Bylaws
Chapter 1 - Membership

Section 5. Continuing Medical Education Requirement. In order for an Active or Senior Active dues-paying or Associate member of this Society to remain a member in good standing of the Society after December 31, 1975, he must have qualified for the American Medical Association's Physician's Recognition Award, which award is currently based upon a three-year continuing medical education program, which in this instance commences on July 1, 1972. Each Active or Senior Active dues-paying or Associate member once he has qualified for the American Medical Association's Physician's Recognition Award, must continue to qualify for such award in order to remain a member in good standing of the Pennsylvania Medical Society. The Board of Trustees and Councilors shall, in accordance with procedures established by such Board, have the power to waive such requirements in those cases involving Active or Senior Active or Associate members of this Society serving temporarily in the Armed Forces or other Government service of the United States or prevented from the practice of medicine by reason of illness or disability or in such other cases as in its judgment such waiver should be granted. The Board shall waive such requirements upon application from any Associate Member not actively engaged in the practice of medicine. Special student members are exempt from the Continuing Education Requirement.

Section 6. Suspension from Membership. The membership of a member in this Society shall be suspended (a) on December 31 of any year (beginning in 1975) if he is an Active or Senior Active dues-paying or Associate member who has failed to qualify for the American Medical Association's Physician's Recognition Award provided the Office of the Executive Vice President has given such member sixty days notice prior to December 31 that such suspension will be invoked against him unless such member shall submit sufficient supplemental records to fulfill such award requirements by December 31, and such suspension shall be for a period of one year, (b) upon suspension of his membership in his Component Society, and (c) upon the effective date, as provided in Section 7 of Chapter XII of these Bylaws, of an order to that effect issued by the Judicial Council of this Society. The suspended member shall not be entitled to exercise any of the rights or privileges of membership during the period of suspension, shall be required to continue the payment of annual assessments without any reduction whatsoever, and shall be restored to full membership upon the expiration of the period of supension provided he has qualified for a current AMA Physician's Award Certificate.

Section 7. Termination of Membership. The membership of a member of this Society shall terminate (a) in the case of Active or Senior Active or Associate Members suspended pursuant to subsection (a) of Section 6 of this Chapter who have not completed the continuing medical education requirement for the AMA Physician's Recognition Award by the end of the one year period of suspension, (b) upon (i) termination of his membership in his Component Society for any reason whatsoever, or (ii) failure to pay a delinquent assessment within thirty days after notice of such delinquency as provided in Section 2 of Chapter IX of these Bylaws, or (iii) three months after ceasing to be eligible for membership herein in the class of membership in which he is a member as specified in the Constitution, unless at such time an application of certification for another class of membership for which the member will become immediately eligible is pending in the office of

the Executive Vice President of this Society, and (c) upon the effective date, as provided in Section 7 of Chapter XIII of these Bylaws, of an order to that effect issued by the Judicial Council of this Society. Any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year, and reinstatement by his Component Society, but no such member under any circumstances shall be considered to be an Active, Senior Active, Intern or Resident member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purposes of any section of the Constitution or these Bylaws. Any Active or Senior Active dues-paying or Associate member whose membership has been terminated by reason of failure to meet the requirements for the AMA Physician's Recognition Award shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met all the requirements for such award for a current period and that at least one-third of the hours required were obtained during the current calendar year.

(Secretary's Note: Three-fourths vote required.)

Subject Ten
Change in Membership Categories Constitution and Bylaws

Proposal of the Allegheny County Medical Society

The following amendment has been received by the Office of the Secretary pursuant to Article XV of the Constitution. The effect of this amendment, if adopted, would be to give members reaching the age of 65 a choice between Senior Active and "Emeritus" membership categories. The new "Emeritus" membership category would replace the current Associate Membership category. The "Emeritus" members would retain most of their membership benefits, but would lose the right to serve on any but temporary committees subject to appointment by the President. *If the House of Delegates adopts the following amendment creating an Emeritus category of membership, technical changes in the Society's Bylaws will be required.*

Article IV - Membership

Section 4. [Associate] Emeritus Member

An [Associate] Emeritus Member of this Society shall be a physician who (i) is [seventy] sixty-five years of age or over and (ii) has been an Active or Senior Active Member of this Society, a service member of the American Medical Association, or an active member of a constituent association of the American Medical Association for a continuous term of thirty years and (iii) does not wish to be a Senior Active Member as provided in Article IV, Section 3.

Such [Associate] Emeritus member shall have the right to this class of membership upon certification in due form by the component society to the Executive Vice President of this Society; and thereafter such [Associate] Emeritus member shall not be required to pay any annual assessment.

(Secretary's Note: Two-thirds vote required.)

For the information of the House of Delegates, the following is the exact text of the amendments to the Constitution and Bylaws of the Allegheny County Medical Society

Article III—Membership

Section 3. [Associate] Emeritus Membership

A. Qualifications

An [Associate] Emeritus member shall be an Active member who has been a member of this Society, or of a component society of the Pennsylvania Medical Society, or an Active member of a constituent association of the American Medical Association for a continuous term of 30 years immediately preceding and is not less than [70] *65* years of age, who does not wish to be a Senior member as provided in Article III, Section 2 C (2).

B. Rights and Privileges

[Associate members have the right to Associate membership in the Pennsylvania Medical Society. They] Emeritus members shall receive the Bulletin to Allegheny County Medical Society. They are entitled to the benefits of the Medical Benevolence Fund and Educational Fund. They may serve on special or temporary committees at the invitation of the President. They may attend any Business or Scientific meeting and have the privilege of the floor.

They may not vote or hold office or serve on any standing committees. [They are not entitled to the benefits of the Medical Defense Fund.] They are not entitled to Emeritus status in the Pennsylvania Medical Society.

C. Election

Application for [Associate] Emeritus membership shall be made to the Membership Committee in writing before January 1 for consideration and approval at the January meeting of the Board of Directors.

Article IV-Fees, Dues and Assessments

Section 3. Schedule of Dues

B. Other Members

[Associate] Emeritus, Affiliate, Visiting and Honorary members shall be exempt from the payment of dues.

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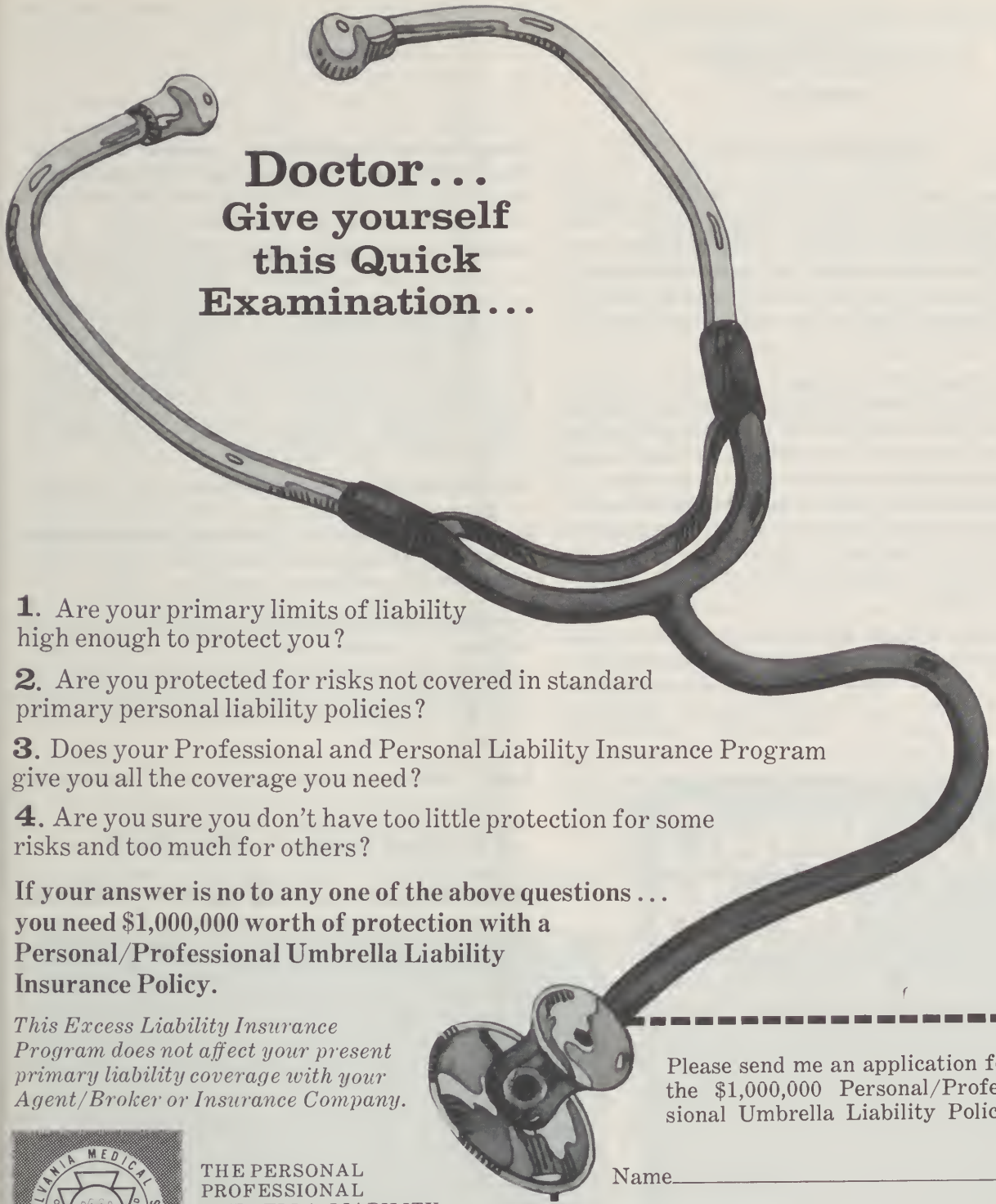

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*AVAILABLE ON REQUEST. Ronald I. Goldberg, M.D. & Franklin L. Shuwall, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Walter F. Ciesielski**, Conshohocken; Temple University School of Medicine, 1926; age 73; died June 5, 1974. He is survived by his wife and four daughters.

• **Charles K. Fetterhoff**, Harrisburg; University of Pennsylvania School of Medicine, 1934; age 63; died June 12, 1974. He was chairman of the department of obstetrics and gynecology at Harrisburg Hospital and clinical professor of obstetrics and gynecology at the Milton S. Hershey Medical Center, Pennsylvania State University. Dr. Fetterhoff was a fellow of the American College of Surgeons and of the American Academy of Obstetrics and Gynecology. His wife, a son, and a daughter survive him.

• **William C. Hunsicker, Jr.**, Northeast, Md.; Hahnemann Medical College and Hospital, 1927; age 71; died March 18, 1974. He was a fellow of the American College of Surgeons and the International College of Surgeons. He was certified by the American Board of Urology. He is survived by his wife.

• **Orlando A. Lazzaro,** Philadelphia; Jefferson Medical College, 1928; age 70; died May 13, 1974. He was a member of the American Association of Ophthalmologists and the International College of Surgeons. He is survived by his wife, a daughter, and a sister.

• **Herbert Lipshutz,** Philadelphia; Jefferson Medical College, 1944; age 54; died May 8, 1974. He was head of plastic surgery at Pennsylvania Hospital and clinical professor at the University of Pennsylvania School of Medicine. Dr. Lipshutz was a member of the American Association of Plastic Surgeons, the American Society of Plastic and Reconstructive Surgery, and a fellow of the American College of Surgeons. His wife, his mother, three daughters, and a brother survive him.

• **Smith D. Morton**, Pittsburgh; Temple University School of Medicine, 1934; age 69; died June 14, 1974. He is survived by his wife, a son, and a daughter.

• **Lewis S. Reese,** Kingston; Jefferson Medical College, 1921; age 79; died May 7, 1974. He had practiced in Kingston for fifty years. His wife and a daughter survive him.

• **Leo F. Scanlan,** Philadelphia; University of Pennsylvania School of Medicine, 1917; age 80; died May 5, 1974. He was formerly chief of surgery at St. Agnes Hospital and was appointed surgeon emeritus in 1960. He is survived by a daughter, a sister, and a brother.

• **Bertram Shaffer**, Wyncote; University of Pennsylvania School of Medicine, 1931; age 68; died June 17, 1974. He was chief of dermatology at Albert Einstein Medical Center and became chief emeritus in 1971. He was associate professor of dermatology at the University of Pennsylvania School of Medicine and a member of the graduate school teaching staff. He was a fellow of the American Academy of Dermatology, the Society of Investigative Dermatologists, and of the American Dermatological Association. His wife, two daughters, two sisters, and a brother survive him.

• **John W. Shirer,** Pittsburgh; University of Pittsburgh School of Medicine, 1925; age 74; died July 6, 1974. Dr. Shirer was president of the Pennsylvania Medical Society in 1957-58 and was a past president of the Allegheny County Medical Society. He had been associate professor of surgery at the University of Pittsburgh School of Medicine. Dr. Shirer was on the senior staff of Magee-Womens Hospital and Children's Hospital of Pittsburgh and on the emeritus staff of Presbyterian University Hospital. He was certified by the American Board of Surgery and was a member of the American College of Surgeons, the Pittsburgh Academy of Medicine, the Clinical Pathology Society, and was a member of the Board of Directors of the International College of Surgeons. His wife, two sons, four daughters, and two brothers survive him.

• **Henry T. Simmonds, Jr.,** New Cumberland; University of Pennsylvania School of Medicine, 1942; age 57; died May 18, 1974. He was former chairman of the radiology department at Harrisburg Hospital. He was a member of the American Roentgen Ray Society, the American College of Radiology, and the Eastern Radiological Society. He is survived by a daughter and a son.

• **William W. Unangst,** Collegeville; University of Pennsylvania School of Medicine, 1947; age 52; died May 3, 1974. He was head of the alcoholic and drug unit at the Norristown Hospital. He practiced in Philadelphia and also in Collegeville. His wife, Dorothy C. Unangst, M.D.; a daughter; a son; a brother, Howard Unangst, M.D.; and both his parents survive him.

• **Walter Weinberger,** Hollidaysburg; University of Vienna Medical School, Vienna, Austria, 1924; age 74; died May 8, 1974. He served at the Hollidaysburg State Hospital for fifteen years. He was a member of the Academy of Dermatology and the American Psychiatric Association. He is survived by his wife, a son, and a sister.

• **Ralph C. Wilde,** Pittsburgh; University of Pittsburgh School of Medicine, 1951; age 51; died July 10, 1974. Dr. Wilde was a member of the Board of Trustees and the current president of the Pennsylvania Medical Society and had served as president of the Allegheny County Medical Society. He had been clinical assistant professor of surgery at the University of Pittsburgh School of Medicine since 1963. Dr. Wilde was head of the division of surgery at Allegheny General Hospital, a member of the staff at Presbyterian University Hospital, the associate staff of Children's Hospital of Pittsburgh, and the consulting staff at Eye and Ear Hospital of Pittsburgh. He was a fellow of the American College of Surgeons and the Pittsburgh Surgical Society. He is survived by his wife and two daughters.

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Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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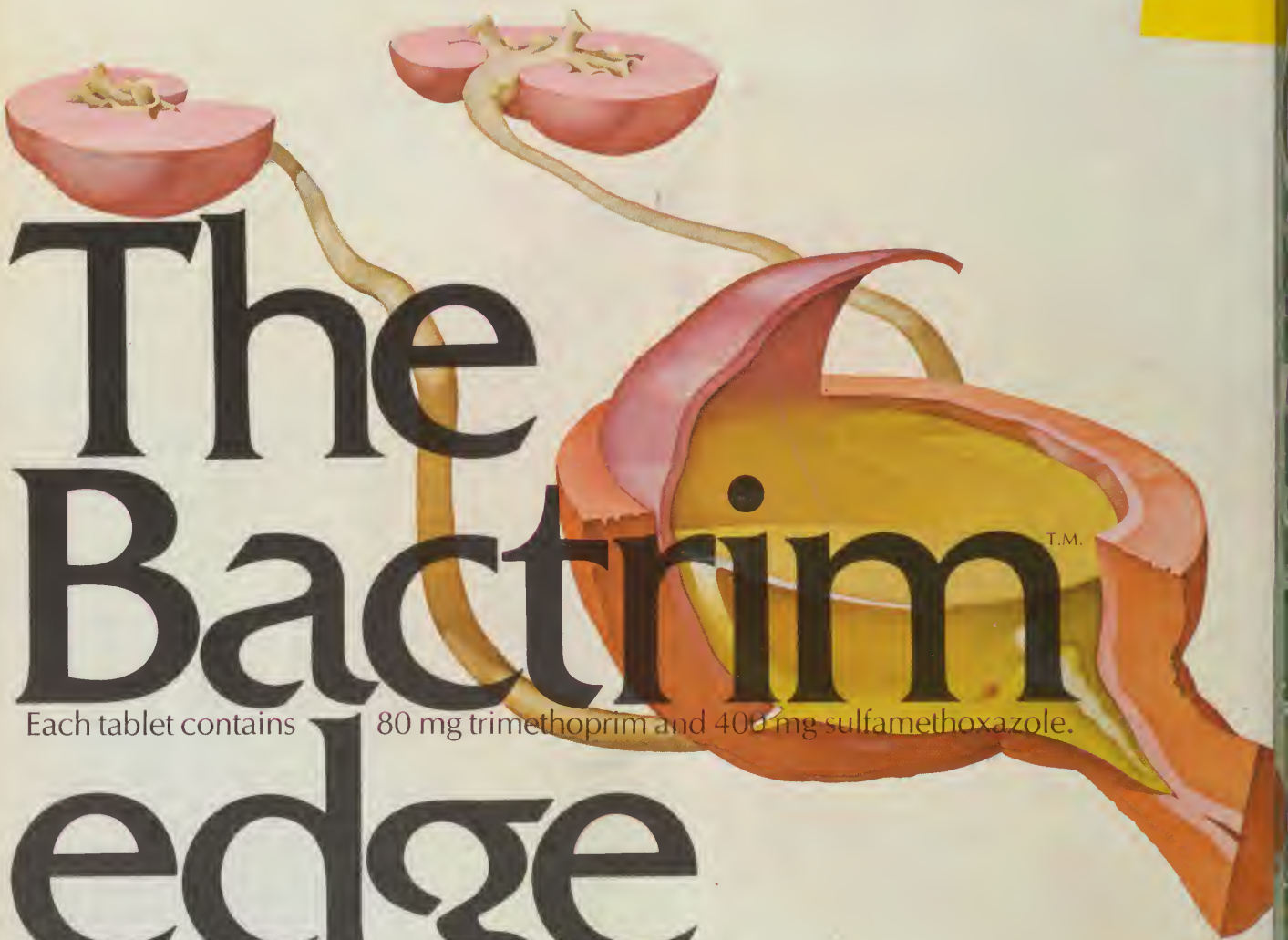

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pennsylvania medicine

September 1974

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pennsylvania medicine

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medigram

September 1974

BOARD VOTES APPROVAL OF BLUE SHIELD PLAN C The Board of Trustees at its August 14 meeting voted approval of income limits of $6,000 for individuals and $12,000 for families for Blue Shield's new Plan C and referred the action to the members of the House of Delegates for ratification. House members have received information relative to the balloting by mail in August, and replies are being returned now.

DR. SCHLAGER, SOCIETY SECRETARY, RESIGNS The Board of Trustees received with regret the resignation of Charles E. Schlager, M.D., York, from the post of Society secretary and appointed G. Winfield Yarnell, M.D., of Harrisburg, to fill the unexpired term. Dr. Yarnell is currently a member of the Council on Public Service.

BOARD PROTESTS SECTION OF LAB RULES The Society's Board at its August meeting voted to protest a section of the rules implementing the Clinical Laboratory Act which calls on laboratories to notify patients of charges. In a letter to Secretary of Health J. Finton Speller, M.D., Chairman of the Board Cyrus B. Slease, M.D., said "We view (the section) as inimical to the physician/patient relationship and an over-extension of the department's legal authority." An article on the new rules appears on page 11 of this issue.

NEW DEPARTURES AT HOUSE SESSION The Reference Committee on Rules will hold an open hearing before the opening session of the House of Delegates October 10 to consider a request that county society executives be permitted to sit with their county delegations. Because of a resolution adopted at the 1973 House, it is expected there will be at least two candidates for the office of vice speaker, regardless of the outcome of the recommendation of the Reference Committee on Constitution and Bylaws, which will consider the matter at this session. The Annual Meeting of Administrative Members of the Pennsylvania Medical Care Foundation will take place at Annual Session on Friday afternoon. The call to the meeting and the Foundation's annual report will be sent to administrative members late in September.

COOPERATIVE IN FINAL PHASE OF MEMBERSHIP DRIVE The Pennsylvania Medical Cooperative is in the final phase of its charter membership campaign. September 30 is the deadline established by the Council on Public Service, Robert N. Moyers, M.D., chairman, said. The council's campaign to recruit 2,000 physician members at a one-time membership fee of $100 was mandated by the 1973 House of Delegates. The purpose is to realize savings by mass purchasing of medical office supplies. Facing the Medigram is a tear-out card for the convenience of Society members who have not yet joined.

PRESIDENT SIGNS PENSION REFORM BILL President Gerald R. Ford has signed the Employee Benefit Security Act, placing pensions under federal control and affecting physicians by permitting them increased

savings toward retirement. Those using the Keogh plan now can contribute 15 percent of annual earnings to a maximum of $7,500, whichever is less, (old limits were 10 percent and $2,500. Individuals participating in professional corporations can set aside an amount which will result in a pension equal to $75,000 per year or 100 percent of the participant's average compensation for his high three years of income, whichever is lower.

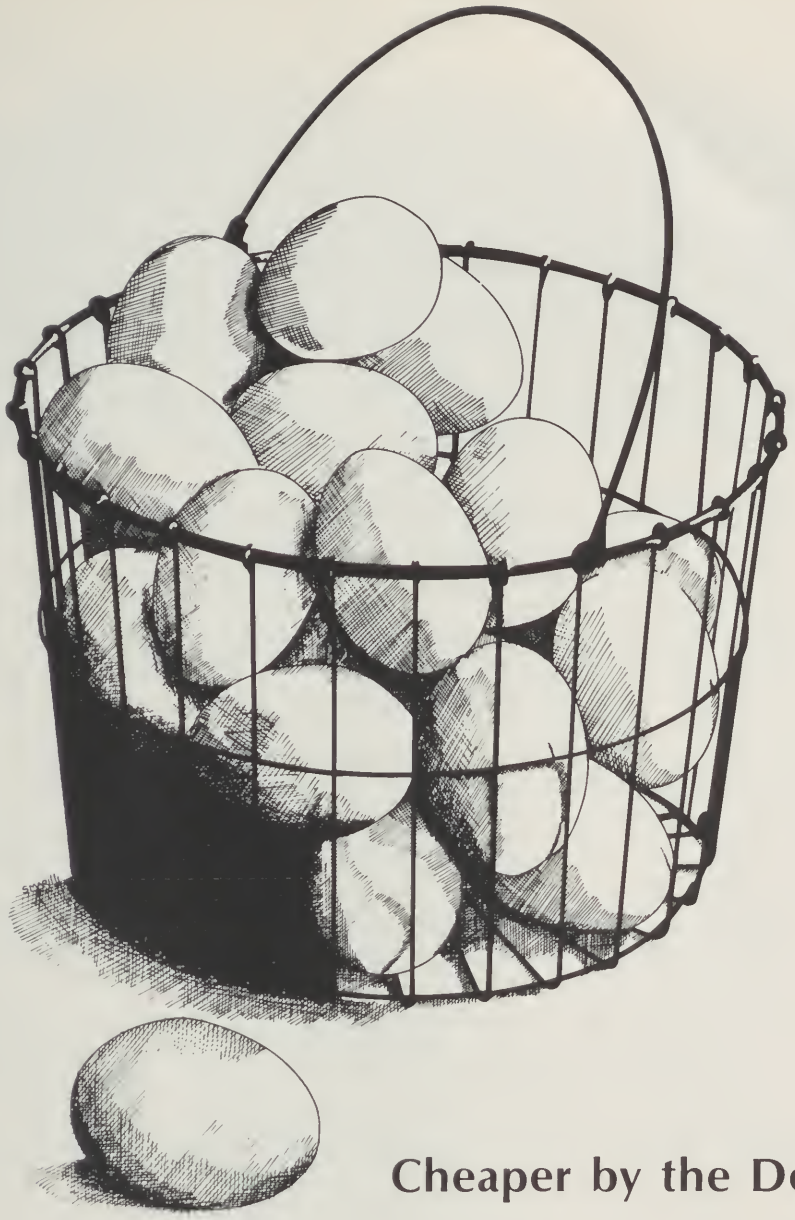
MEDICAL DATA RELEASE CLARIFIED A joint communique from the Hospital Association of Pennsylvania and the Pennsylvania Medical Society issued July 19 calls on hospital medical staffs to play an active role in the drafting of proposed policies on the use and disclosure of medical records. It further urges hospitals to be guided by Hospital Medical Records: Guidelines for Their Use and Release of Medical Information, American Hospital Association Publication No. M80 12M-5/72-2156. Growing concern regarding the release of data and information to third parties led to the joint communique.

PENNSYLVANIA M.D.s RECEIVE MAIL IN ERROR Some 2,000 Society members holding current AMA Physician's Recognition Awards recently received a PRA application in error when a general mailing was made by the AMA to Pennsylvania physicians. If you have a 1972 or 1973 PRA, the Council on Education and Science has said to ignore the recent mailing. You will be notified appropriately when your next application is due.

NEW IMMUNIZATION RULES NOW IN EFFECT Effective August 3, rules issued by the Department of Health require immunization against diphtheria, tetanus, poliomyelitis, measles, and rubella for all children entering school for the first time. The rules call on school officials to ensure that all new students are immunized or to arrange an immunization program shortly after the opening of school. Physicians may find themselves deluged with calls from parents, but school openings will not be delayed and students will not be barred from school this year.

OCTOBER IMMUNIZATION ACTION MONTH The Center for Disease Control of the United States Public Health Service has declared October "Immunization Action Month." The Pennsylvania Department of Health is the state agency for the project. At the national level, the AMA is cooperating in the effort, as is the State Society on the state level. Goal of the program is to increase the number of children immunized against poliomyelitis, measles, mumps, rubella, diphtheria, tetanus, and pertussis.

RETROSPECTIVE REVIEW TO END OCTOBER 1 The Department of Public Welfare has announced that retrospective review of hospitalizations under medical assistance will end October 1 when a concurrent review system will be initiated throughout the state. Hospitals have chosen either the department's Pre-Discharge Utilization Review (PDUR) or the option to implement a concurrent utilization review system approved by the department. The Certified Hospital Admissions Monitoring Program (CHAMP) developed by the Pennsylvania Medical Care Foundation has been cited by the department's Medical Assistance Memorandum N. 60, Supplement No. 2 as an acceptable alternate to PDUR.



Cheaper by the Dozen!

A 30 to 50 per cent saving on the cost of expendable office supplies is a mighty appealing prospect these days. And that is exactly what you can look for when you join the Pennsylvania Medical Cooperative—the mass-buying organization being formed to serve physicians exclusively.

The Cooperative, which will effect its savings by purchasing in large volume directly from the manufacturer and reselling to the physician at cost, will limit itself to expendable supplies in the initial phase of its operation only. Later when it expands its inventory to include more costly items such as surgical supplies and office equipment, the potential for savings will be even greater.

Membership in the Cooperative will be open to Pennsylvania Medical Society members only. The only cost is a nominal $100 once-and-done lifetime membership fee, all or a substantial part of which will be returned if you should decide to withdraw. In all probability you will save more than the amount of the membership fee in your first-year purchases alone.

However, dollar savings are not the only benefit. The Cooperative's system of blanket contracts and automatic shipments will do much to simplify your purchasing procedures and reduce the burden of inventory control.

You'll like the Cooperative, we're sure. For further information, please write or call.

Pennsylvania MEDICAL Cooperative

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Another New Benefit to Members of Pennsylvania Medical Society

Continuing education... now a PMS membership requirement

membership requirement made easy

Physicians who received the 1972 AMA Physician's Recognition Award (PRA) should now be accumulating credits toward their 1975 application (the expiration date of their present award).

Physicians who have applied for the 1973 AMA Physician's Recognition Award may now begin accumulating credits toward their 1976 application (the expiration date of the 1973 award).

Physicians who have not yet applied for an AMA Physician's Recognition Award should be accumulating credits so that as soon as they have acquired the full 150 hours (with a minimum of 60 hours in Category One) they will be ready to apply for either the 1974 or 1975 award.

All Physicians must fulfill the necessary requirements by the end of 1975 in order to retain PMS membership (except for new members who will have three years in which to meet the requirement).

Each Physician thus establishes his own three-year cycle with his application covering his three year credits prior to his application date.

It is not nearly as complicated as it sounds:

(1) Accumulate and record the necessary credits;

(2) When sufficient credits for an award have been accumulated, transfer the information from your file folder to your PRA application form;

(3) Continue to acquire and record credits in a new file folder so that toward the expiration of your own individual three-year cycle, you will have accumulated and recorded sufficient credits to transfer to your new application. A new application will be sent to you automatically at the proper time for your next required application.

The Council on Education and Science, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, Pa. 17043—Telephone (717) 238-1635—will be glad to answer any individual questions you may have.

for your bulletin board

TO MY PATIENTS . . . . . .

Periodically throughout the year I may be away attending scientific continuing education programs. This is part of my obligation of being a member of the professional Pennsylvania Medical Society. At times this may inconvenience you as my patients because of my nonavailability. For that I am truly sorry, but for your benefit my participation in continuing medical education keeps me up to date on new techniques and procedures. It sharpens my skills as a physician and renews my capabilities to deliver the best possible medical care to you.

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Check the Program's key features—each of significant value to you...

★ No member's application can be rejected without the applicant having the right to request the State Society's review and concurrence...

★ Five year coverage cannot be canceled or non-renewed (except for non-payment of premium) without consent of the State Society following the insured's appeal for review...

★ State Society "peer review" of individual claim or suit settlement disputes...

★ Primary coverage available up to and including limits of $1,000,000...

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★ Extensive involvement by State Society in underwriting, claims, classification statistics and rate-making developments...

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Plan now on participating... with the State Society acting as the physician's "Ombudsman," it's like having your own insurance company... only better!

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☐ I am interested in participating in the PMS Liability Insurance Program. Please send me an application.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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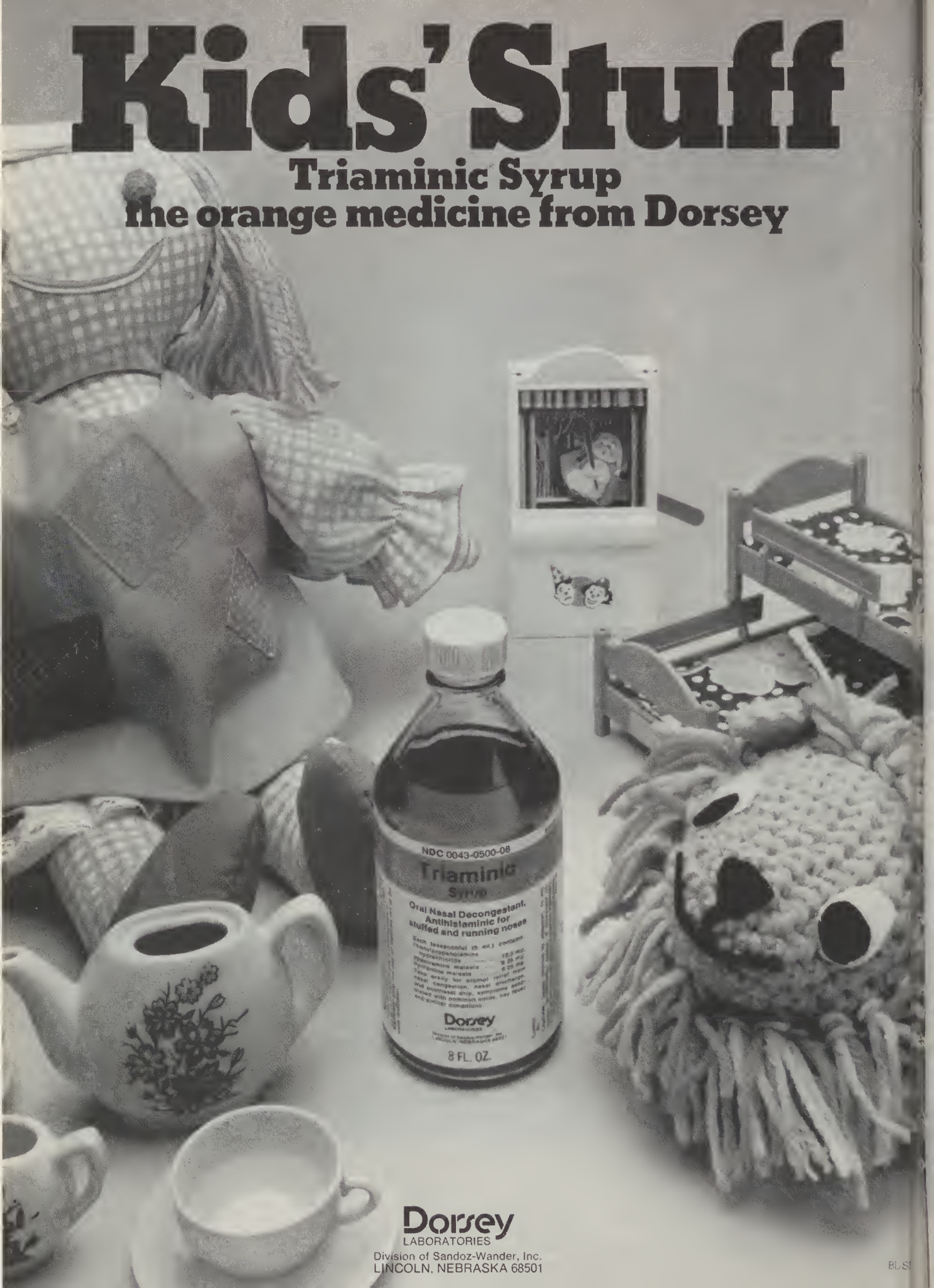

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Society presents position to party platform committees

The Society's position on health care in the Commonwealth approved by the Board of Trustees May 15 was presented to the platform committees of the Republican and Democratic Parties at their hearings in Harrisburg during the past month. The full text appeared in the August issue of PENNSYLVANIA MEDICINE beginning on page 30.

DR. CRANE

DR. MASLAND

David S. Masland, M.D., Society vice president, appeared before the Republican Platform Committee at the first presentation July 30. A. Reynolds Crane, M.D., president, presented testimony and answered questions when the Democratic committee met August 6.

REPUBLICAN PLATFORM COMMITTEE

DEMOCRATIC PLATFORM COMMITTEE

Burn data sought

The Pennsylvania Division of the American Trauma Society is requesting representatives of Pennsylvania hospitals to report their capabilities in the treatment of severe burn victims.

The trauma society is in the process of gathering listings of such facilities for publication in PENNSYLVANIA MEDICINE for the benefit of primary care physicians. Of special interest is each hospital's capability in the areas of acute care, plastic and reconstructive surgery, and comprehensive rehabilitation.

Chairmen of departments of surgery in all medical schools in the Commonwealth have cooperated in supplying this information. Any non-university hospital to which severe burns may be referred is asked to help in the compilation of a comprehensive listing by contacting William E. DeMuth, Jr., M.D., Department of Surgery, The Milton S. Hershey Medical Center, Hershey, Pa.

STEPHEN J. BARRETT, M.D., presented the Society's testimony when the Pennsylvania Chiropractic Society petitioned the Department of Transportation for the right to perform physical examinations required to be issued a driver's license. A member of the Society's Committee on Quackery, Dr. Barrett, centered at the conference table (right), told the committee that the proposal "is extremely dangerous to public health and safety."

M.D. office labs excluded

Final clinical laboratory regulations published

Private physicians' office laboratories were excluded from the final regulations of the new Clinical Laboratory Act published on June 15, 1974. This was a victory for the Society which had objected to the inclusion of office laboratories in the draft regulations.

The Department of Health, however, noting receipt of fourteen objections to the deletion, promised a separate set of rules and regulations for physicians' office laboratories later.

According to Robert H. Craig, Jr., director of governmental affairs, the Society will resist the inclusion of office labs based on the statutory definition worked out during passage of Public Law 279. It defined a "clinical laboratory" as:

> "Any place, establishment or institution organized and operated **primarily* for the performance of all or any bacteriological, biochemical, hematological, microscopical, serological or parasitological or other tests . . . This definition includes, but is not limited to, all independent, hospital, industrial, state, county, and municipal laboratories."

The only laboratories exempted under the act are federal laboratories and research laboratories in which results are not applied to patient care.

The question of who may submit specimens to a clinical laboratory is open to interpretation. The Society had hoped to pin it down to medical doctors and doctors of osteopathy. In this regard it received the support of the Hospital Association of Pennsylvania which in circular letter number 642 on May 24, said;

> "A question was recently raised concerning the use of hospital facilities—principally laboratory and x-ray services—by chiropractors in the Commonwealth. With the advice of the HAP Committee on Patient Care Services, the Board of Trustees has approved a statement urging member institutions to honor requests for diagnostic and treatment services of only those professional individuals whose qualifications meet the requirement for admission to the hospital staff as provided by the hospital's bylaws."

The Department of Health Regulation is not as precise. Section 5.41 states:

> "Specimens shall be accepted or collected from patients by a clinical laboratory only when tests are requested on such specimens **by a member of the healing arts licensed to practice in Pennsylvania,* or other persons authorized by law, or authorized agents of the foregoing."

There is also a reporting requirement which says:

> "Reports of clinical laboratory findings shall be made only to the persons submitting the specimen or requesting the analysis, or his authorized agent."

None of this requires that any laboratory or physician *must* accept a specimen from these persons such as chiropractors who in the broadest definition fall under the blanket of the "healing arts" but who are not qualified to properly apply laboratory data. Once a specimen or referral is accepted, however, the information must be released to the referring source and the question then comes forth as to whether the physician or laboratory would be aiding and abetting someone to break the law in practicing medicine without a license.

Ethical standards of the new act specifically prohibit "rebates" or other types of "fee splitting inducements." Blanket fee contracts are out. Volume discounts may be given but the fee schedule must clearly indicate them and they must be offered to all clients. Except for volume discounts "only a single fee schedule shall be maintained and applied by a licensed laboratory."

Notifying patients of charges for tests is called for under Section 5.48 entitled, "Disclosure of Charges:"

> *"The notification of all charges for laboratory tests performed for the patient must be sent to the patient by the clinical laboratory unless the patient has been billed directly or otherwise notified of such charges by said laboratory."*

This disclosure provision came under fire at the Board of Trustees meeting on August 14. The Council on Governmental relations said that the law itself does not provide any base for such a regulation. The Board acted on the advice of the

(Continued on page 36)

*emphasis added

Pennsylvania
PSRO Chairmen and Staff Members

Area	Chairman	Project Director
I	**Robert B. Stuart, M.D.** Northwestern Pennsylvania PSRO 1565 West 38th Street Erie 16508 Telephone (814) 864-1765	
II	**C. Jack Rodgers, M.D.** Central Pennsylvania Area II PSRO 511 West Fourth Street Williamsport 17701 Telephone (717) 322-9843	**Paul P. John** Central Pennsylvania Area II PSRO Box 26, 699 Rural Avenue Williamsport 17701 Telephone (717) 323-3786
III	**Edwin C. Neville, M.D.** Northeastern Pennsylvania PSRO Medical Arts Building Scranton 18503 Telephone (717) 344-1231	
IV	**David A. Tilly, M.D.** Eastern Pennsylvania Health Care Foundation, Inc. 1746 Allen Street Allentown 18104 Telephone (215) 433-3143	**William Prettyman** Eastern Pennsylvania Health Care Foundation, Inc. 65 East Elizabeth Avenue, Suite 203 Bethlehem 18018 Telephone (215) 865-1481
V	**Raymond J. Saloom, D.O.** Midwestern Pennsylvania PSRO Area V 301 Prairie Street Harrisville 16038 Telephone (412) 735-2100	
VI	**James R. Dornenburg, M.D.** Allegheny PSRO 121 North Highland Avenue Pittsburgh 15206 Telephone (412) 441-9300	**John Kuhn** Allegheny PSRO Suite 450, One Allegheny Square Pittsburgh, Pennsylvania 15212 Telephone (412) 231-1706 or 231-1707
VII	**Donald C. Brown, M.D.** Southwestern Pennsylvania PSRO Greengate Professional Building U.S. Route 30 West Greensburg 15601 Telephone (412) 837-5757	**Sandra Levine** Southwestern Pennsylvania PSRO 825 N. Main Street Greensburg 15601 Telephone (412) 836-5858
VIII	**Thomas Skrentny, M.D.** Highlands PSRO Corporation 1214 Thirteenth Avenue, Rear Altoona 16601 Telephone (814) 942-8420	**Michael Kohler** Highlands PSRO Corporation Room 325 - Swank Building Johnstown 15901 Telephone (814) 535-5493
IX	**Robert B. Edmiston, M.D.** Southcentral Pennsylvania PSRO 3301 Schoolhouse Lane Harrisburg 17109 Telephone (717) 652-5380	**Harold Diehl, Jr.** Southcentral Pennsylvania PSRO 2401 N. Fourth Street Harrisburg 17110 Telephone (717) 233-0273 or 233-8650
XI	**John L. Steigerwalt, M.D.** Montgomery/Bucks PSRO 1509 Montgomery Avenue Rosemont 19010 Telephone (215) 525-3335	**Ralph M. Rolan, III** Montgomery/Bucks PSRO Merion-Towle Building, Suite 103 Blue Bell Office Campus Township Line and Walton Road Blue Bell 19422 Telephone (215) 542-9118
XII	**Sidney O. Krasnoff, M.D.** Philadelphia PSRO 1351 West Tabor Road Philadelphia 19141 Telephone (215) 549-4929	**Richard M. Nelson** Philadelphia PSRO 2100 Spring Garden Street Philadelphia 19130 Telephone (215) 563-5343

PSROs in Pennsylvania move into planning phase

Professional Standards Review Organizations (PSROs) in eight of the twelve areas established by HEW have been funded for the planning phase of their activity and three additional organizations are preparing to submit planning contract applications as soon as new Department of Health, Education, and Welfare funding regulations are published.

The Pennsylvania Medical Care Foundation in its capacity as PSRO Support Center is continuing to assist the officers and staff members of the eleven areas in the planning phase and in preparation of grant applications.

Area X (Delaware and Chester Counties) has not yet formally organized.

Listed below are the counties included in each of the established areas. On the facing page is a chart listing the chairmen and staff personnel of the organizations now functioning.

Area 1: Erie, Potter, Elk, Warren, Crawford, Cameron, McKean, Forest.

Area 2: Tioga, Centre, Columbia, Bradford, Union, Snyder, Clinton, Northumberland, Mifflin, Lycoming, Montour, Juniata, Sullivan.

Area 3: Susquehanna, Lackawanna, Luzerne, Wyoming.

Area 4: Wayne, Monroe, Northampton, Pike, Carbon, Lehigh.

Area 5: Mercer, Jefferson, Butler, Venango, Clearfield, Armstrong, Clarion, Lawrence, Indiana.

Area 6: Allegheny.

Area 7: Beaver, Westmoreland, Fayette, Washington, Greene.

Area 8: Cambria, Huntingdon, Bedford, Blair, Somerset.

Area 9: Schuylkill, Berks, Franklin, Perry, Cumberland, Adams, Dauphin, Lancaster, York, Lebanon, Fulton.

Area 10: Chester, Delaware.

Area 11: Bucks, Montgomery.

Area 12: Philadelphia.

Practice management seminar repeat planned for November

A second medical practice management seminar will be presented by the PMS Council on Education and Science Friday, November 15 and Saturday, November 16, at Chatham Center in Pittsburgh. The first seminar, which was held at Hershey May 10-11, was regarded by attendants as an unqualified success.

Leif C. Beck, LI.B., president of Management Consulting for Professionals, Bala Cynwyd, will head the faculty. He is a member of the Society of Professional Business Consultants, author of the monthly series on management in PENNSYLVANIA MEDICINE, editorial consultant for *Medical Economics*, and an expert on taxation, professional corporations, and medical management.

Other faculty members are Roger Harrison, C.P.B.C., owner of Roger Harrison Associates, Inc., Norman, Oklahoma, past president and chairman of the board of examiners of the Society of Professional Business Consultants, and editorial consultant to *Medical Economics*. He has seventeen years of experience as a business consultant to physicians. Thomas E. Zirkle, C.P.B.C., co-owner of Professional Management Associates, Inc., of Chicago and Denver, is immediate past president of the Society of Professional Business Consultants, a contributing author to *Prism*, author of the book, "Corporate Practice," and a lecturer on practicing law programs.

Topics to be discussed include office facilities and equipment, personnel administration, medical administration, fees and fee control, billing and collection systems, office bookkeeping and accounting requirements, group practice matters, and the management of professional corporations. Also covered are considerations in employing physicians, the meaning of HMOs to medical practice, and personal financial and estate planning.

Methods for the protection of the physician against encroaching nonprofessional control of medicine and new ideas on the sound organization of the physician's practice will give participants an opportunity for questions and discussion.

Further information and registration forms may be obtained from the Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, Pa. 17043. Telephone (717) 238-1635.

Educational Assembly scheduled for October 23-25

A new approach to scientific sessions for health professionals is being taken in the form of a series of continuing education programs to be held October 23-25 at the Host Inn, Harrisburg, under the sponsorship of the Pennsylvania Medical Society.

Programs will be presented by Hahnemann Medical College, the Pennsylvania Orthopaedic Society, the American Association of Medical Assistants, the Pennsylvania Academy of Physical Medicine and Rehabilitation, the Pennsylvania Psychiatric Society, the Robert H. Ivy Society, the Pennsylvania Chapter of the American College of Surgeons, and the Council on Education and Science of the Pennsylvania Medical Society.

For a listing of programs available, together with fees and a preregistration form, refer to page 34 of this issue of PENNSYLVANIA MEDICINE.

PLANNING for the Long Term Care Program to be held under the auspices of the PMS Council on Education and Science Oct. 24 and 25 at the Host Inn, Harrisburg, are (left to right): Herman W. Gruber, staff secretary of the AMA Council on Aging; Nathan Sussman, M.D., Harrisburg, member of the PMS Council on Education and Science; and Maurice E. Linden, M.D., Philadelphia geriatric psychiatrist, who is consultant to the AMA Council on Mental Health.

MCP offers retraining

The Medical College of Pennsylvania will conduct its next retraining program for physicians who have been inactive but wish to re-enter the field of clinical medicine this fall, Nina B. Woodside, M.D., M.P.H., program director, has announced.

The program has been conducted since 1968 and was first intended to assist women physicians, but both men and women physicians have participated in the six-week programs. Over sixty have completed the retraining to date, and almost all have returned to active medicine either as residents or practitioners, Dr. Woodside said.

Further information is available from Dr. Woodside at the college, 3300 Henry Ave., Philadelphia 19129.

Physicians responsible for nursing home care

The responsibility for quality of care in nursing homes rests with the physician, according to a report by Maurice E. Linden, M.D. to the AMA Council on Mental Health and the Committee on Aging. Dr. Linden is chief of geriatric psychiatric services at Jefferson Medical College of Thomas Jefferson University, Philadelphia.

He blamed the nursing home crisis on physician noninvolvement caused by a preoccupation with physical diagnosis and a lack of interest in the emotional troubles of geriatric patients.

While recognizing that unrealistic federal reimbursement guidelines deter physician interest, he named three definite areas in which improvement could result: (1) medical school curricula, (2) continuing medical education, and (3) physician involvement in new legislation. He concluded that increased physician awareness of the possibilities of raising the quality of care through recognition of medical, emotional, and social needs would contribute to dissipation of the sense of desertion, unworthiness, and fear of death so prevalent in these geriatric patients.

Allergists elect

Newly elected officers of the Pennsylvania Allergy Association for 1974-75 are: Harold Kreithen, M.D., Allentown, president; Philip Fireman, M.D., Pittsburgh, president elect; D. Lee Miller, M.D., Pittsburgh, secretary; and Charles W. Woodcock, M.D., Harrisburg, treasurer.

The 1974-75 Pennsylvania Medical Society Roster, containing component county society officers, component county society members with addresses and specialty codes, and an alphabetical roster of PMS members showing county affiliation, is now available. A complimentary copy may be requested by PMS members. Additional copies are $15 each.

Commonwealth has new Medical Practice Act

ROBERT L. LAMB
Director of Communications

A journey which began in the summer of 1971 was successfully concluded on July 22 when Governor Milton J. Shapp signed House Bills 759 and 760 into Acts 189 and 190 providing physicians in the Commonwealth with a new Medical Practice Act.

Under the new act, physician membership on the State Board of Medical Education and Licensure remains the same. The five physicians currently serving on the board are: John W. Robertson, Jr., M.D., chairman (surgeon from Philadelphia); William J. Kelly, M.D., vice chairman (internist from Pittsburgh); Richard C. Lyons, M.D. (surgeon from Erie); Raymond C. Grandon, M.D. (internist from Harrisburg); and Philip E. Ingaglio, M.D. (general practitioner from Philadelphia). Two members of the state board also sit on the PMS Board of Trustees: Raymond C. Grandon, M.D., (Fifth District), and William J. Kelly, M.D., (Tenth District).

Added are a "public representative" (consumer) and "a person who is knowledgeable in the field of allied health sciences."

The ex officio members remain the same: the secretary of health and the commissioner of professional and occupational affairs. This brings the total voting membership of the board to nine.

The new law calls on the State Society to submit a list of qualified candidates to the governor for appointment to the board but permits him to go outside the list to fill vacancies. Terms run four years from the date of appointment.

Secretary of the board is Mrs. Alva Cockley, a state career employee with twenty-two years of service. Her status remains unchanged under the new law.

Despite sentiment in the House to move the health profession licensing boards to the Department of Health, the final Senate version keeps them in the Bureau of Professional and Occupational Affairs under the Department of State.

One troublesome issue was whether to require a medical school dean on the State Board of Medical Education and Licensure. The 1968 House of Delegates said yes. But testimony at the 1973 Annual Session ran against the proposal, and the policy was changed. The new law requires only that the five physicians be licensed and registered in Pennsylvania.

Abortion Penalties Raised

Defining an abortion as "the practice of surgery," the act adds new penalties for unlicensed persons convicted of performing abortions. "The person convicted thereof shall be guilty of a misdemeanor and shall be subject to a fine of not less than ten thousand dollars ($10,000) or imprisonment for five years, or both."

Control of Physicians' Assistants Deleted

Section 4, giving the state board authority to regulate physicians' assistants ran into trouble in the Senate. Concurrence came when both houses

AT THE Delaware County Medical Society's recent awards dinner held at the Holiday Inn in Tinicum, Edward G. Torrance, M.D., (right) of Mercy Catholic Medical Center, Philadelphia, receives a fifty-year PMS award from Leroy A. Gehris, M.D., Second District trustee and councilor.

WHEN Sami Michael, M.D., secretary of the Carbon County Medical Society, visited State Society headquarters for orientation, LeRoy C. Erickson, right, director of educational activities, briefed him on the Society's educational requirement for continued membership and activities of the Council on Education and Science. Dr. Michael spent a day with members of the staff at Society Headquarters to learn more about the Society's functions.

agreed to legislate physicians' assistants separately.

Physician-Nurse Rules Authorized

To accommodate the changing role of nurses, the medical board and the State Board of Nurse Examiners may jointly issue regulations. A new Professional Nursing Act also was signed in August.

Licensing

The Board will issue four broad types of licenses:

(1) Unlimited license to practice medicine and surgery.

(2) Temporary license valid for twelve consecutive months to participate in approved graduate medical training in an assigned hospital.

(3) Limited license which can be granted to foreign medical graduates who have attained "true status of teacher . . . ."

(4) Midwifery, physical therapy, and drugless therapy.

Board Final Arbiter of Medical Education

Although rarely forced to use them, the state board has far-reaching powers over medical education in Pennsylvania. Not only may it set standards for acceptance to medical school, but it has authority over school curricula and training. The board also has power over hospital intern and residency programs and can, if the programs fail to meet board standards, refuse to license their graduates or permit students to enroll in their programs.

Foreign Medical Graduate Certificate Required

Foreign medical school graduates, except those from Canadian medical colleges, must complete the standard educational requirements *and* be certified by the Educational Council for Foreign Medical Graduates.

Board Required to Examine

While requiring the medical board to hold two examinations per year, the law closely regulates retakes. An applicant who fails has two years in which to take the examination a second time. Two-time losers must take a year of graduate study approved by the board before trying again.

The new act permits the medical board to accept in place of its own examination proof of having passed other exams such as the National Boards or the FLEX exam. FLEX stands for "Federation Licensure Examination," an exam sponsored by the Federation of State Licensing Boards. FLEX questions come from the pool of the National Board of Medical Examiners. Last December, Pennsylvania became the forty-sixth state to join the FLEX system.

Choice of Reciprocity or Endorsement

The board may establish either reciprocity agreements with other states or transfer by endorsement. Most states have reciprocity agreements, which means that the state to which a doctor is moving will accept and grant him a license if it holds a reciprocity agreement with his home state.

Pennsylvania presently does not have reciprocity agreements with any state. Doctors coming to Pennsylvania from other states must apply for a license. Doctors from Pennsylvania moving to other states must apply for licensure in their new state and have that application returned to the Pennsylvania State Board of Medical Education and Licensure for endorsement.

National Health Service Corps Physicians Exempt

Exempt from the licensing requirement of the new act are federally employed physicians. The list includes: military physicians, U.S. Public Health Service physicians, VA doctors, and "physicians employed with federal services, while in discharge of their official duties." It also permits out-of-state doctors to be called in for consultation. Physicians who live across the state line and work in Pennsylvania can file a copy of their home state license with the state board provided their state affords similar courtesy to Pennsylvanians.

Graduate Certificates Maintained

Residents licensed in other states who apply for training programs in Commonwealth hospitals still will receive a "graduate certificate" for training in that institution, but the hospital is prohibited from substituting staff service for training.

Biennial Registration Retained

The biennial registration with its fee and certificate of registration is retained. The two-part card sent out upon payment of the fee includes a portion designed as a wallet card. At the time of the gas strike these cards were used as identification to entitle physicians to emergency gas supplies.

Treasury Gets Money

With underfinancing of the board a perennial problem, early drafts called for the board to retain its revenue. Unable to give special treatment to

one of the boards, legislators insisted that license income revert to the state treasury. This places the board back squarely in the middle of the annual battle of the budget.

Disciplinary Powers Strengthened

There are more details on conditions in which the board may "refuse, revoke or suspend" a license.

1. Failing to meet the licensing standards or violation of board rules.
2. "Making misleading, deceptive, untrue or fraudulent representations in the practice of medicine; practicing fraud or deceit in obtaining a license to practice medicine and surgery; or making a false or deceptive biennial registration with the Board."
3. "Being convicted of a felony in the courts of this Commonwealth or any other state, territory or country. Conviction as used in this paragraph shall include a finding or verdict of guilt, an admission of guilt, or a plea of nolo contendere."

This language answers the question whether the state board can suspend or revoke licenses for conviction of income tax evasion or medicare fraud. Clearly the board can do so.

Disabled Physician Controlled

The new law defines the disabled physician as:

> "Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals or any other type of materials, or as a result of any mental or physical condition."

Under this clause the board may compel a physician to submit to a mental or physical examination by board designated doctors. Failure to do so can be considered admission to the allegations. In refusing to take the required exams, a doctor waives his rights, opening the way for the board to take final action against him. Options include the power to refuse, revoke or suspend a license.

The underlying goal of the disabled physician clause is treatment and rehabilitation. This is encouraged by language which permits the treated doctor to demonstrate his improved condition and capacity to resume practice.

Extends to Immoral, Unprofessional Conduct

Sleeper of the new Medical Practice Act is section 15, subsection 8, dealing with immoral and unprofessional conduct. The language is broad:

> "Unprofessional conduct shall include any departure from, or the failure to conform to the standards of acceptable and prevailing medical practice, in which proceeding actual injury to a patient need not be established."

Probation Power Added

Here are the disciplinary options open to the medical board under Act 190:

1. Deny the application for a license.
2. Administer a public or private reprimand.
3. Revoke, suspend, limit, or otherwise restrict a license.
4. Require licensee to submit to care, counseling, or treatment by a physician or physicians designated by the board.
5. Place a licensee on probation with the right to remove probation.

Due Process Guaranteed

While disciplinary powers are broad, all are subject to due process safeguards of the 1945 "Administrative Agency Law." They include the right of notice, hearing, and adjudication at which the accused has the right to counsel and cross examination. Finally there is the right of appeal.

Rule Making Authorized

Rules and regulations are the hidden part of the legislative iceburg. The Society will analyze the rules which the medical board promulgates under the new act, and reports will follow.

Hypnotism Excluded

At the last minute, control of hypnosis was excluded, a concession to organized labor to protect entertainer hypnotists who are members of the theatrical unions.

Handbook now available

A handbook designed to aid physicians in identifying their own individual needs and interests in the area of continuing medical education is available from the Illinois Council on Continuing Medical Education.

Worksheets are provided enabling the physician to select learning objectives and integrate his education into a cohesive plan directed toward the needs of his own patients, replacing a continuum of isolated learning experiences that may satisfy the educational requirements of organizations but may not yield the highest return in time invested.

For a copy, write the Illinois Council on Continuing Medical Education, 360 N. Michigan Ave., Chicago, Ill. 60601. The cost is $1.00.

Health department publishes drug law rules, regulations

Two requirements particularly objectionable to physicians were deleted from the final regulations of Act 64 of 1972, "The Controlled Substance Drug, Device and Cosmetic Act." The regulations were published in the July 6, 1974 edition of *The Pennsylvania Bulletin*.

The first deletion was the requirement that every dispensing practitioner report monthly on forms provided by the Department of Health the name of each person to whom a Schedule II substance is sold, dispensed, distributed or given away.

The other required every duly licensed practitioner in possession of a current Drug Enforcement Administration registration to report to the Department of Health on his stationery or on department forms those patients whose diagnosis indicates diseases or a pathology which may require the prescribing of controlled substances in Schedule II over an extended period or in increasingly large doses.

Both these requirements have been dropped from the final regulations.

Telephone authorization of Schedule II substances is still permitted but only under the following emergency conditions:

> "(a) That immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user; and
> (b) That no appropriate alternative treatment is available including administration of a drug that is not a controlled substance under Schedule II of the Act."

The quantity of a drug dispensed under emergency conditions is limited to the amount adequate for the emergency.

If the pharmacist does not recognize the voice of the physician he must make a reasonable effort to verify it. This may include a call back.

Here is the follow-up required after phoning in a prescription:

> "Within seventy-two hours after authorizing an emergency oral prescription, the prescribing practitioner shall have a written prescription for the emergency quantity prescribed delivered to the dispensing pharmacist. In addition to conforming to the requirements of these regulations and Act 64 the prescription shall have written on its face 'authorization for emergency dispensing' and the date of the oral order . . . ."

Failure to follow up in writing on an oral prescription within 72 hours can cause problems for both the physician and the pharmacist.

> "The pharmacist shall notify the nearest office of the Federal Drug Enforcement Administration if the prescribing individual practitioner fails to deliver a written prescription to him; failure of the pharmacist to do so shall void the authority conferred by this Section to dispense a controlled substance without a written prescription of a prescribing individual practitioner."

The label on a dispensed drug container shall include:

- Name of the drug
- Quantity and the manufacturer's name if the drug is a "generic."
- When the physician indicates that the name of the drug should not appear on the label, the recognized national drug code number shall be placed on the label if such a number is available.
- Drugs which have full potency for less than one year must include the statement "Do Not Use After (manufacturer's expiration date) or similar wording."

The regulations specifically state that both pharmacist and physician must abide by these labeling requirements.

Paregoric is included under Schedule III of the Act and may not be sold, dispensed or given away except pursuant to an oral or written prescription.

Under the final regulations, "all prescriptions for controlled substances shall be written in indelible ink, indelible pencil or typewriter and include:

> (a) the date of issue
> (b) the name and address of the patient
> (c) directions for administration
> (d) the name, address, and Federal Drug Enforcement Administration Registration number of the prescribing practitioner
> (e) the signature of the prescribing practitioner
> (f) the Federal Drug Enforcement Administration registration number cannot be preprinted on the prescription form."

A prescription may not be used by a physician to obtain controlled substances for use in his routine office practice nor for general dispensing to patients.

"A prescription may not be issued for the dispensing of controlled substances listed in any schedule to a drug dependent person for the purpose of continuing his dependence on such drugs, nor in the course of conducting an authorized clinical investigation in a narcotic dependency rehabilitation program."

editorials

Pharmaceutical advertising—change needed

Although the practice of sending unsolicited drug samples through the mail has not been as prevalent in recent years as it once was, the physician still receives a certain amount of this material. Not only are drug samples sent, but an increasing number of eye-catching pharmaceutical advertisements flood the individual doctor's office. Free trade journals, better known to medical personnel as "throw-aways," are also abundant and are largely supported by drug advertisements which appear in them. Free journals would, in all likelihood, die a very quick death were the pharmaceutical industry's financial assistance withdrawn.

The long-continued habit of sending unsolicited drugs through the mail should be curtailed. Drug samples ought not to be used as promotional material for advertising campaigns. Some physicians feel that this type of publicity leads to overprescribing and lends itself to abuse. Drug samples are useful in that they may be used to initiate a therapeutic regimen or to determine an individual patient's response to therapy. In cases like these, samples should be sent only upon the written request of the physician.

Another practice of pharmaceutical firms is to give "gifts" in return for stocking their particular product. The acceptance by doctors of valuable nonmedical gifts in return for product usage is unethical. Several examples come to mind. One such example is a company that gives expensive pens to physicians. Calendars, note pads, desk blotters, pens, pencils, and appointment books are daily reminders of the pharmaceutical industry. This may be one of the reasons Congress is considering legislation change to govern prescription writing.

Bulk rate mailing of drug advertisements borders on the deplorable. Sometimes two or three of the same advertisement finds its way to the physician's desk during a given month. Mailing costs are by no means cheap, and many of these colorful and imaginative efforts simply clutter up the wastebasket because, although they are factual, they are not very educational. Throw-away journals are appropriately named because they, too, clutter the wastebasket. A busy physician barely has time to read the journals to which he subscribes so that the "free" journal receives little more than a passing notice of the cover.

There are a number of solutions to these problems which might lower the escalating cost of drugs. Refuse to accept "gifts" and unsolicited drug samples and return all items of this sort. If, by law, all drug advertisements and samples had to be sent by first class mail (and then only upon request), drug prices would almost certainly decline. If free journals were sent only to those physicians who request them, circulation would decline, but the assurance that they were read would increase.

Funds might be rechanneled into more beneficial uses. Money now spent on gimmicks and gadgets could be used to subsidize good educational programs for physicians. Pharmaceutical houses might sponsor speakers and produce more worthwhile, up-to-date films and other learning systems. A good, knowledgeable speaker is worth more educationally to a physician than a year's supply of free journals and repetitious ads.

David A. Smith, M.D.
Medical Editor

Who should do gastrointestinal endoscopy?

The advent of modern endoscopy, especially using fiberoptic instruments, has truly revolutionized the practice of gastroenterology. Among the accomplishments of upper gastrointestinal endoscopy has been the discovery of peptic ulcers in 25 percent more persons than previously disclosed by x-ray, the uncovering of hiatus hernia in over 50 percent more cases, the establishment of erosive gastritis and/or aspirin ingestion as the number one cause of upper G-I bleeding, and the clarification of duodenitis as a clinical entity. It has also made possible cannulation of the papilla of vater, aiding in the diagnosis of biliary and pancreatic diseases. In addition, gastric polypectomies are being done, often as outpatient procedures, saving patients from abdominal surgery, hospital bills, and prolonged loss of work. Similar accomplishments are being performed by fiberoptic colonoscopy and peritoneoscopy.

Therefore, there is a growing need for hospitals

to have guidelines when granting endoscopy privileges to staff appointees. The following criteria for performing endoscopy has been approved by the American Society of Gastrointestinal Endoscopy:

A. The gastrointestinal endoscopist shall either (1) be a member of the American Society for Gastrointestinal Endoscopy (ASGE) or (2) be recommended by two ASGE active members or (3) be eligible for admission.

B. The gastrointestinal endoscopist shall have documented training under a recognized program with demonstration of proficiency in each of the following procedures he or she desires to perform—esophagogastroscopy, gastroscopy, gastroduodenoscopy, duodenoscopy with endoscopic retrograde cholangiopancreatography, colonoscopy, and laparoscopy.

C. Polypectomy, either in the upper intestinal or lower intestinal tract through fiberoptic instruments, is considered a separate procedure requiring additional training. The endoscopist seeking privileges will have at least five cases observed for each of the above listed procedures by an active member of the ASGE (qualified or recognized in that field) and that member will then recommend action to be taken on the endoscopist's application for privileges.

D. Each of the above procedures will be considered separately. In selected situations, such as in documented extensive past experience, the observation of the endoscopist's procedures may be waived at the discretion of the ASGE member.

Regis A. Wolff, M.D.
Allegheny General Hospital
Pittsburgh

Trauma society growing

In August 1973, PENNSYLVANIA MEDICINE carried a report concerning the emerging Pennsylvania Division of the American Trauma Society. At that time the Pennsylvania Division had just been incorporated, the first to be organized in the United States.

Presently twenty more state divisions are incorporated, and it is anticipated that by January 1975, at least ten more will be active. It should be but a short time until all states have active divisions.

There are more than 2,000 founder members in the United States, and the Pennsylvania Division is proud of the fact that more than ten percent reside in the Commonwealth. As expected, the early founder group was comprised mostly of physicians. Now nonphysicians are joining in increasing numbers. From the beginning, participation by nonphysicians was believed to be the promise of success for this fledgling organization, and the heartening response by lay people augurs well for growing public support for prevention of accidental death and disability.

Units are being organized throughout the state, and shortly all interested agencies such as ambulance companies, safety engineers, educational institutions, professional organizations, and all sectors of public and private life will have an opportunity to join in implementing meaningful programs geared to solve community problems related to traumatic injury.

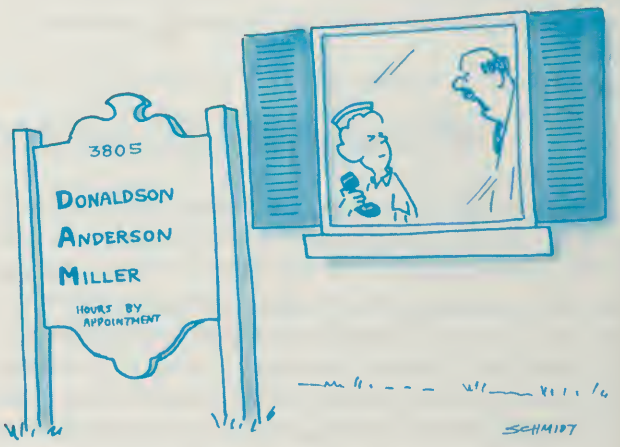
If the members of the Pennsylvania Medical Society continue to support the American Trauma Society as they have so far, the citizens will rapidly become more aware of means of improving all emergency medical services. A growing number of physicians are becoming involved in this vital aspect of primary care and many of these have joined the society.

Those desiring to participate are urged to contact any of the following unit officers:

Samuel P. Harbison, M.D.
Department of Surgery
School of Medicine
University of Pittsburgh
Pittsburgh, Pennsylvania 15261

Lewis T. Patterson, M.D.
Harrisburg Polyclinic Hospital
Third and Radnor Streets
Harrisburg, Pennsylvania 17105

Carl W. Konvolinka, M.D.
Department of Surgery
Geisinger Medical Center
Danville, Pennsylvania 17821



Will you stop saying "Dam Doctor's Office!"

M.D.s in the news

Henry Hood, M.D., Danville, has become executive director of the Geisinger Medical Center, succeeding **Leonard F. Bush, M.D.**, who will continue to serve as a consultant in the department of orthopedics and in the development office. Dr. Hood has been associate executive director for the past four years. He is a member of the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, the American Trauma Society, and the American Association of Medical Clinics. He is certified by the American Board of Neurological Surgery.

Three grants totalling over half a million dollars have been awarded to two professors at the University of Pittsburgh School of Medicine. **Bernard Fisher, M.D.**, professor of surgery, has received a grant for continuing research study in primary breast cancer therapy and one for the study of the surgical management of the regional lymph node in cancer. **Paul A. Chervenick, M.D.**, professor of medicine, has received a five-year grant for the study of hemotopoietic stem cells with emphasis on the study of leukemia and other malignancies.

Jack D. Myers, M.D., professor of medicine at the University of Pittsburgh School of Medicine, has been named recipient of the Robert A. Williams Award for outstanding contributions to medical education, presented by the American Association of Professors of Medicine.

A number of academic promotions have been announced by the Pennsylvania State Medical College, Hershey. **William P. Graham III, M.D.**, has been named chief of plastic and reconstructive surgery and **Robert B. Greer III, M.D.**, chief of orthopedic surgery. They have both received professorships. Named associate professors are **John W. Burnside, M.D.**, chief of internal medicine; **Allan Lipton, M.D.**, chief of oncology, medicine, and microbiology; **Rodrigue Mortel, M.D.**, obstetrics and gynecology; and **G. Frank O. Tyers, M.D.**, surgery.

Paul A. Branca, M.D., has been appointed director of nurseries at Thomas Jefferson University Hospital. He will direct both the newborn nursery and the intensive care nursery. He succeeds **Mary Louise Soentgen, M.D.**, who has accepted an appointment at Conemaugh Valley Memorial Hospital in Johnstown to establish and direct a regional intensive care nursery. In connection with his new position, Dr. Branca has been appointed associate professor of both pediatrics and obstetrics and gynecology at Jefferson Medical College.

DR. BRANCA

DR. ZECCARDI

Joseph A. Zeccardi, M.D., Society Hill, has been named director of the twenty-four-hour emergency care department at Thomas Jefferson University Hospital—the first pediatrician to direct the department. He is clinical assistant professor of pediatrics at the university's Jefferson Medical College. He succeeds **Joseph Keiserman, M.D.**, who has retired.

Luther Brady, M.D., professor and chairman of the board of radiation therapy and nuclear medicine at Hahnemann Medical College and Hospital, has been named president of the Society of Chairmen of Academic Radiology Departments. He is the first radiation therapist to hold the position.

At the invitation of the U.S. Department of State, **George L. Jackson, M.D.**, director of nuclear medicine, Harrisburg Hospital, attended the International Atomic Energy Association symposium on dynamic radioisotopes in clinical medicine and research in Knoxville, Tenn., recently. Dr. Jackson is one of twelve members of the American College of Nuclear Physicians' Board of Regents.

Medical College of Pennsylvania's alumnae association has elected new officers. They are: **Vera Malisoff, M.D.**, Merion, president; **Margaret G. Wood, M.D.**, Overbrook, president elect; **Rita E. Scott, M.D.**, Jenkintown, vice president; **Susan D. McLeer, M.D.**, Germantown, secretary; and **Gertrude Hight, M.D.**, Germantown, treasurer.

Bernard Sigel, M.D., Philadelphia, has been named dean of the Abraham Lincoln School of Medicine at the University of Illinois. He was formerly dean of the Medical College of Pennsylvania.

Philip J. Ferry, M.D., Kingston, has been elected president of the Pennsylvania Society of Colon and Rectal Surgeons for 1974-75. He is a fellow of the American Society of Colon and Rectal Surgeons.

Roger L. Ladda, M.D., former research and clinical fellow in the children's service and genetics unit of Massachusetts General Hospital and Harvard Medical School, has been appointed assistant professor of pediatrics and chief of the division of genetics at the Milton S. Hershey Medical Center of Pennsylvania State University.

Two Medical College of Pennsylvania physicians have been named emeritus professors in obstetrics and gynecology. **Mary DeWitt Pettit, M.D.**, Bryn Mawr, was formerly chairman of the department of obstetrics and gynecology. She was a former member of the board of directors of the Philadelphia division of the American Cancer Society and is a member of the board of directors of the Wainwright Tumor Clinic Association of Pennsylvania. **Elizabeth Waugh, M.D.**, Philadelphia, has retired after forty-two years of service at the college where she was most recently director of obstetrics and gynecology clinics. She is the 1963 recipient of the Elizabeth Blackwell Annual Award from the American Medical Women's Association. Both physicians are diplomates of the American Board of Obstetrics and Gynecology.

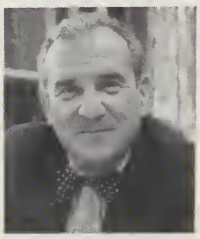
M.D.s in the news

News from Presbyterian-University of Pennsylvania Medical Center, Philadelphia, includes the announcement of several grants to staff physicians. **Zarko M. Vucicevic, M.D.,** associate in the department of ophthalomology, has received a grant from the Pennsylvania Lions Sight Conservation and Eye Research Foundation for research with the laser. **Frank H. Gardner, M.D.,** head of the department of hematology, has received a three-year grant from the National Cancer Institute. In other Presbyterian-University news, **Lawrence C. Parish, M.D.,** associate in dermatology at the center, has been appointed as the only American to the editorial board of *Chronica Dermatologica*. **Harold G. Scheie, M.D.,** director of the Scheie Eye Institute and chairman of the department of ophthalmology at the University of Pennsylvania School of Medicine, has received the Louis Braille Award from the Center for the Blind in Philadelphia. **Robert J. Wolfson, M.D.,** has been elected to the Barany Society, an international society founded in Sweden to stimulate contact among professionals in otolaryngology.

Alma Dea Morani, M.D., Philadelphia, is the second woman surgeon to be elected to the Philadelphia Academy of Surgery. She is president of Medical Women's International Association. Recently she received a Doctor of Human Letters honorary degree from the Chestnut Hill College of Philadelphia in recognition of her services as a medical leader, professor of surgery, and for her humanitarian efforts.

Selma Kramer, M.D., Philadelphia, professor of child psychiatry and head of the section on child psychiatry at Medical College of Pennsylvania, has been appointed chairman of the Committee on Child Psychoanalysis of the American Psychoanalytic Association. She is assistant editor of the Journal of the American Psychoanalytic Association.

Henry A. Shenkin, M.D., Philadelphia, director of the department of neurosurgery and head of the neurosurgery residency program at Episcopal Hospital, has been appointed head of the section of neurological surgery at the Medical College of Pennsylvania. He is a past president of the Philadelphia Neurological Society, a diplomate of the American Board of Neurological Surgery, and a member of the American College of Surgeons.



DR. SHENKIN

DR. ATKINSON

G. William Atkinson, M.D., assistant professor of medicine at Jefferson Medical College, Thomas Jefferson University, has been named director of the division of pulmonary diseases in the department of medicine. He succeeds **Richard Cathcart, M.D.,** who is retiring.

Joel W. Eisner, M.D., chief of the department of medicine at Phoenixville Hospital, has been named a diplomate of the newly established American Board of Allergy and Immunology. The new board is a subspecialty of the American Board of Internal Medicine and the American Board of Pediatrics.

Hasib Tanyol, M.D., of Philadelphia, recently presented a paper coauthored by **Ronald Pennock, M.D.,** Philadelphia, entitled "Etiology of Varicose Veins with Special Emphasis on Chemico Hemodynamics" to the American European Symposium on Venous Diseases in Montreux, Switzerland.

Geisinger Medical Center has appointed several new physicians to the staff. **John B. Houston, M.D.,** Shamokin, is associate director of anesthesiology; **Thomas C. Royer, M.D.,** associate in the department of general surgery and director of the emergency room; and **Anthony P. Turel, Jr., M.D.,** permanent staff in the department of neurology. Dr. Houston had been assistant professor of anesthesiology and director of the residency training program at Temple University Hospital, Philadelphia. Dr. Royer had been on duty at the Beaufort Naval Hospital, Beaufort, South Carolina. Dr. Turel was a postdoctoral fellow in neurology at the Case Western Reserve University School of Medicine.

Robert C. Vannucci, M.D., has joined the department of pediatrics at the Milton S. Hershey Medical Center of Pennsylvania State University, as assistant professor and chief of neurology. He was formerly assistant professor of pediatrics and instructor in neurology at the New York Hospital-Cornell Medical Center, New York City. He was also clinical research fellow in pediatric neurology at Memorial Hospital for Cancer and Allied Diseases in New York.

Charles A. Laubach, Jr., M.D., associate in the department of internal medicine and chief of the section of cardiopulmonary diseases at Geisinger Medical Center, has been elected chairman of the Regional Advisory Board of the Susquehanna Valley Regional Medical Program.

Joseph P. Atkins, Jr., M.D., has joined the staff of Pennsylvania Hospital, Philadelphia, as head of otorhinolaryngology and bronchoesophagology. He was formerly assistant chief in the department of otolaryngology at the U.S. Naval Hospital, National Naval Medical Center, Bethesda, Md.

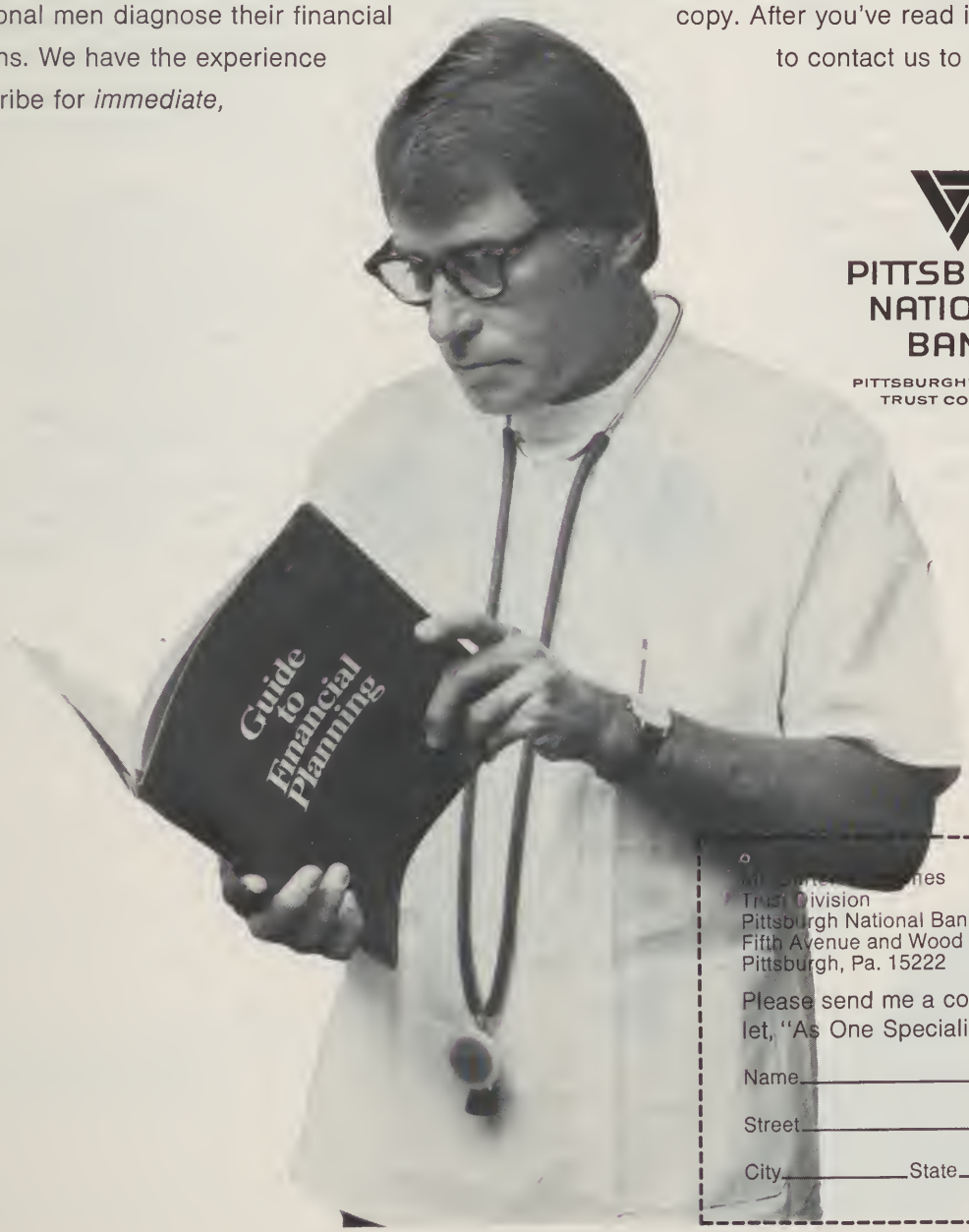
Albert B. Ferguson, Jr., M.D., professor and chairman of the department of orthopaedic surgery at the University of Pittsburgh School of Medicine, has been elected president elect of the American Orthopaedic Association. He is vice president of the American Board of Orthopaedic Surgery and the author of several orthopaedic texts.

Sometimes one specialist needs to see another

Specialized training sets the professional man apart from other businessmen. Similarly, the problems of professional men regarding estate and family responsibilities are unique.

The "specialists" at Pittsburgh National—specialists in investment management, estate settlement, and trusteeship—spend a lot of time helping professional men diagnose their financial conditions. We have the experience to prescribe for *immediate,* as well as *future,* financial needs, with services which free the professional man from needless risks and responsibilities in managing his investments.

We talk about the estate problems of the professional man in our handy booklet, "As One Specialist to Another...". We'd like to send you a copy. After you've read it, you may want to contact us to discuss how we can serve you.



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Trust Division
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Please send me a copy of your booklet, "As One Specialist to Another..."

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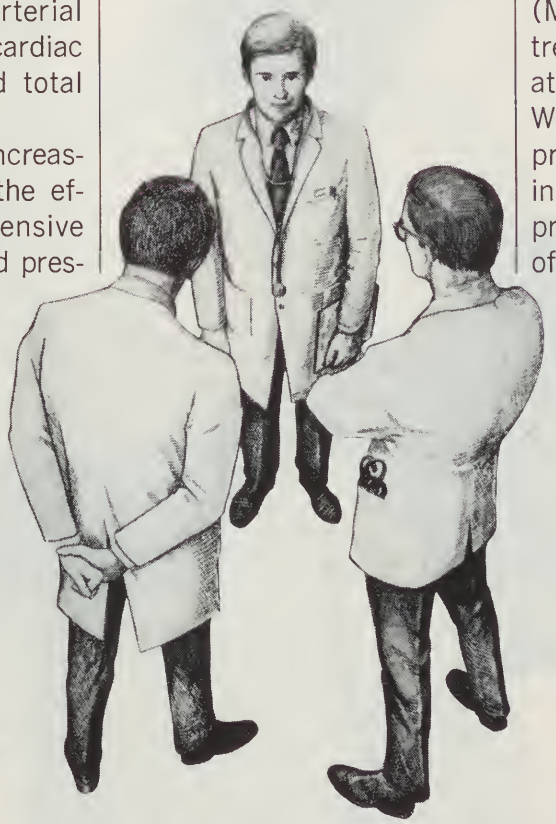
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

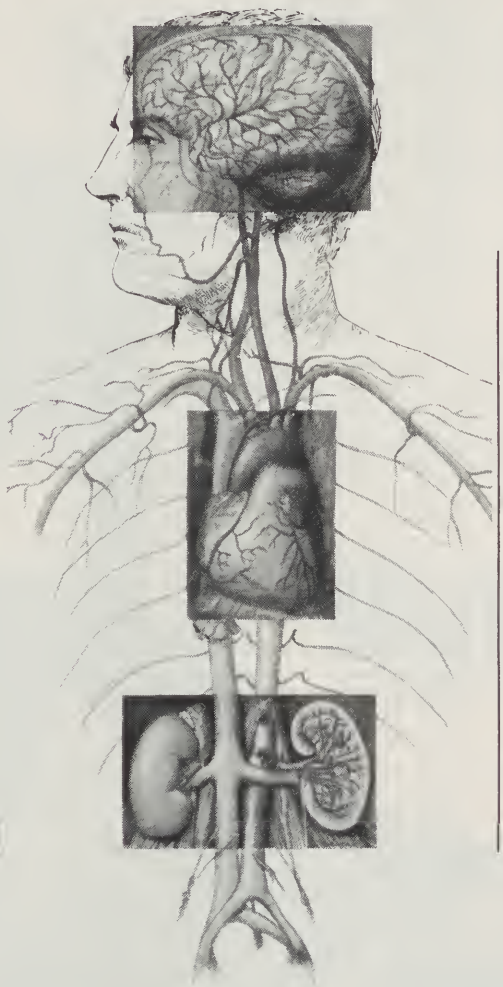
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

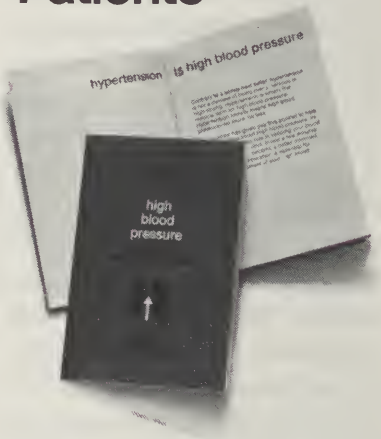
How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

"Required Reading" For Your Hypertensive Patients



Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes... yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

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BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol C III SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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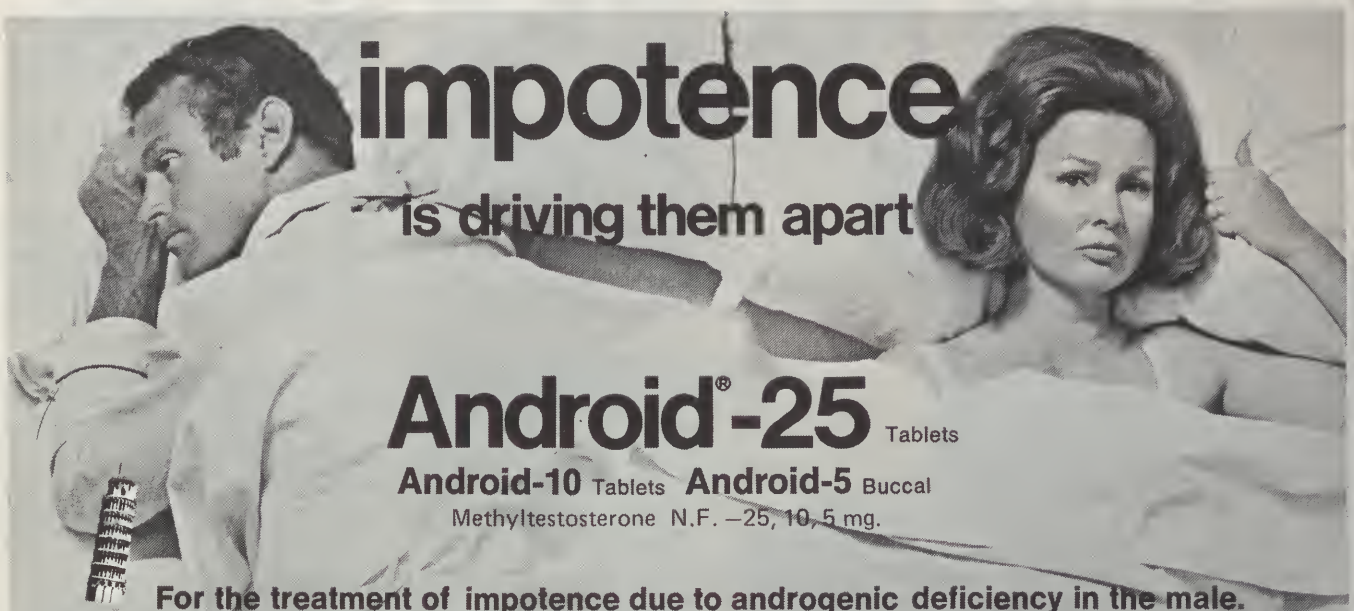

Android®-25 Tablets

Android-10 Tablets **Android-5** Buccal

Methyltestosterone N.F. —25, 10, 5 mg.

For the treatment of impotence due to androgenic deficiency in the male.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonedism. Cholestatic hepatitis with jeundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinome. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. In bottles of 60, 250.

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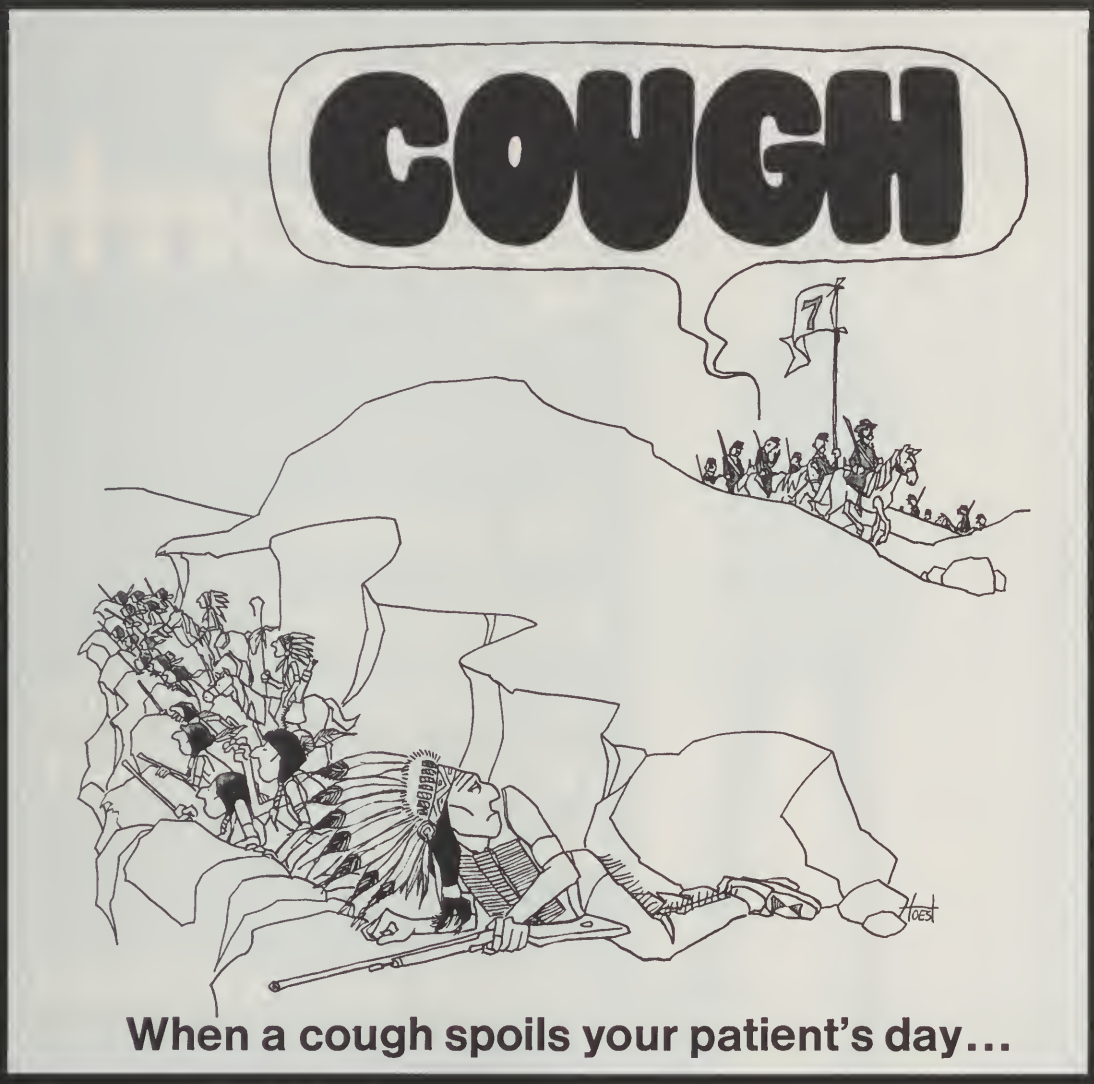

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Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Triaminic® Expectorant with Codeine©

Each teaspoonful (5 ml.) contains:

Codeine phosphate, 10 mg. (Warning: May be habit forming); Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.) glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Triaminic Expectorant with Codeine is a Schedule V controlled substanc

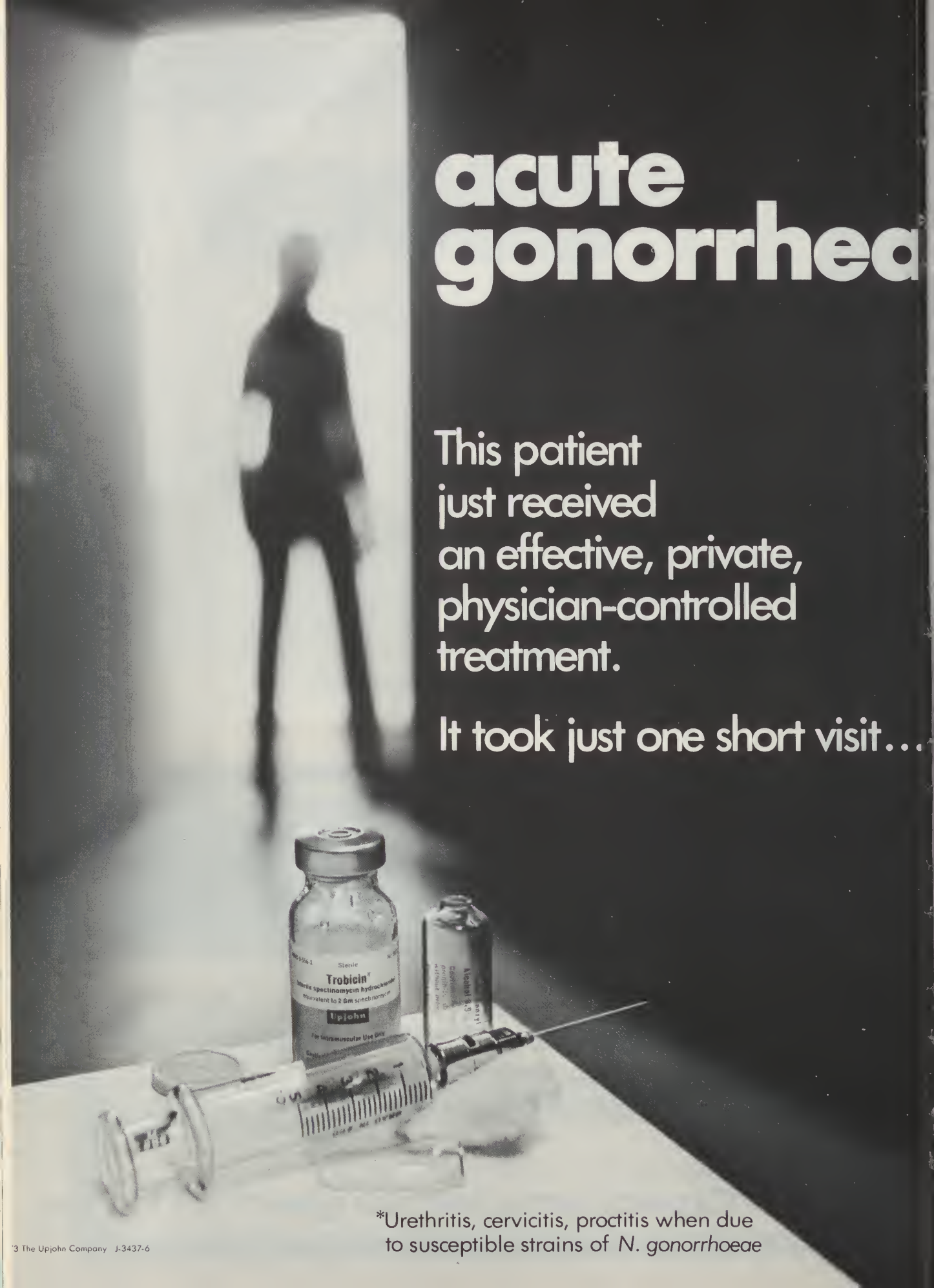
The Adult Expectorants that are great for kids, too.

Dorsey Laboratories/Division of Sandoz-Wander, Inc./Lincoln, Nebraska 68501

acute gonorrhea*

This patient
just received
an effective, private,
physician-controlled
treatment.

It took just one short visit...



*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

'3 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin®

2 gm and 4 gm vials

sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.
Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn

MED B-5-S (MBR-I)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

Second Annual

Friends Hospital Clinical Conference

ADOLESCENCE: DEVELOPMENT AND INTERVENTION

October 3 and 4, 1974

FRIENDS, HOSPITAL, PHILADELPHIA, PENNSYLVANIA

Presented by Friends Hospital in cooperation with the Department of Mental Health Sciences of Hahnemann Medical College and Hospital

Thursday, October 3

Morning

Three Developmental Routes through Normal Male Adolescence — Daniel Offer, M.D.

Family Determinants of Adolescent Psychopathology: the Power of Unconscious Assumptions — Roger L. Shapiro, M.D.

Discussant — Jules H. Masserman, M.D.

Four-way panel discussion
L. D. Tashjian, M.D., Moderator

Afternoon

Genealogy of the Ego Ideal — Peter Blos, Ph.D.

Discussant — Norman D. Weiner, M.D.

Commentary — Jules H. Masserman, M.D.

Evening

Dinner address

Something New Has Been Added on the Way to the Adolescent Forum — Fritz Redl, Ph.D.

Friday, October 4

Morning

Productive Procrastination: Technical Factors in the Treatment of the Adolescent
Peter L. Giovacchini, M.D.

Office Network Therapy with Adolescents
Max Sugar, M.D.

Achievement Place: A Behavioral Approach
Montrose M. Wolf, Ph.D.

The Effectiveness of a Residential Treatment Facility for Adolescents — Eugene J. Yanity, M.D.

Afternoon

Discussant of morning papers
Erwin R. Smarr, M.D.

Six-way panel discussion
Herman D. Staples, M.D., Moderator

Advance registration fee of $75.00 (payable to Friends Hospital) includes lunches at Friends Hospital both days, and dinner Thursday evening at the Hilton Inn Northeast Philadelphia. Category One credit.

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We are searching for two Physicians to join an Emergency Group serving a 500-bed hospital located in a medium-sized city in Northeast Ohio. Group is headed by Board Internist. Congenial atmosphere. Prior experience as Emergency Room Physician not required. Change your life-style to a more normal and regular schedule with considerable more worry-free time off for yourself and family. Starting annual level is $50K with increases in succeeding years - plus other benefits of corporate group. Interested physicians may call or send their curriculum vitae in confidence and with no financial obligation to Arthur A. Lepinot.

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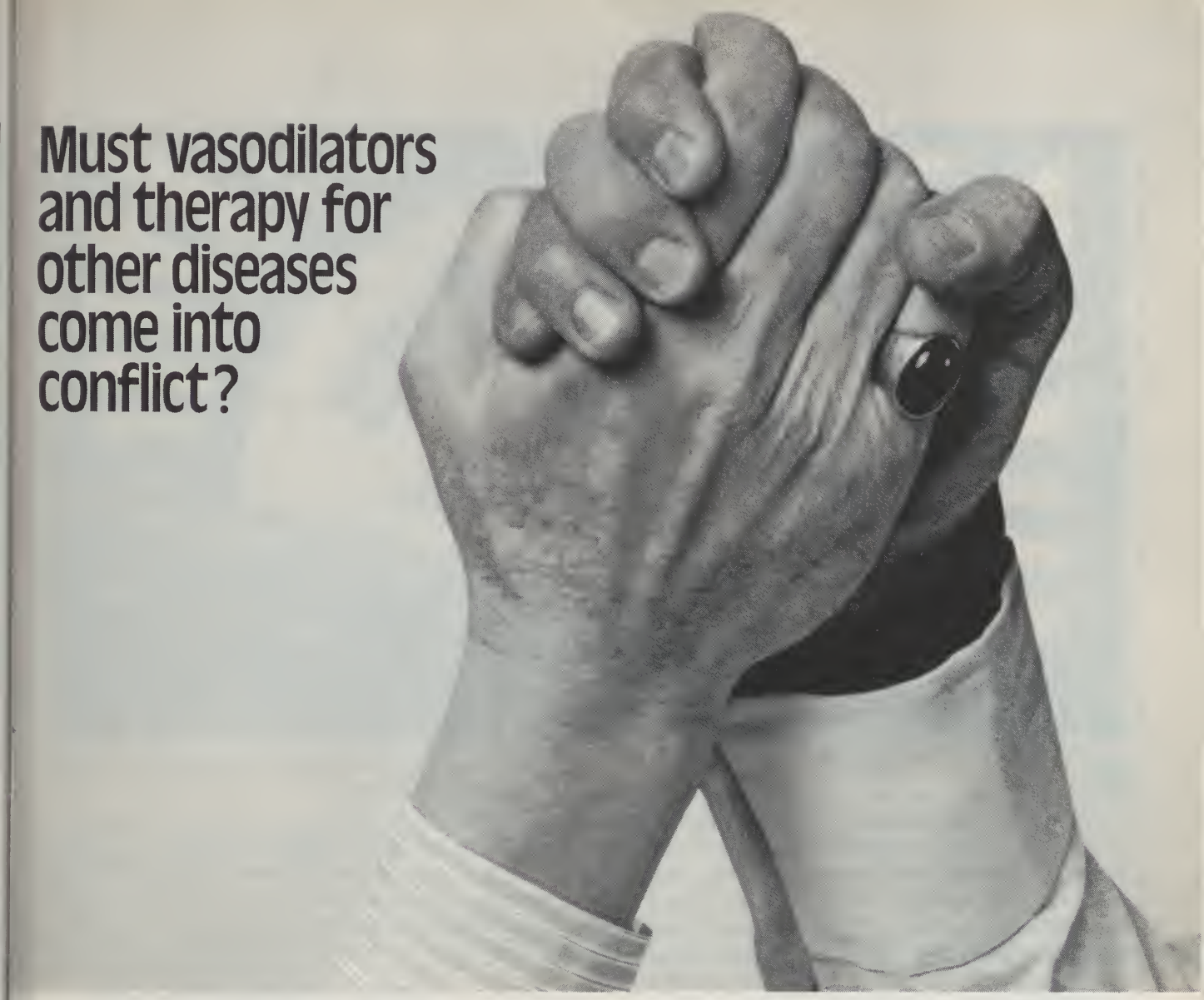
Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25:*134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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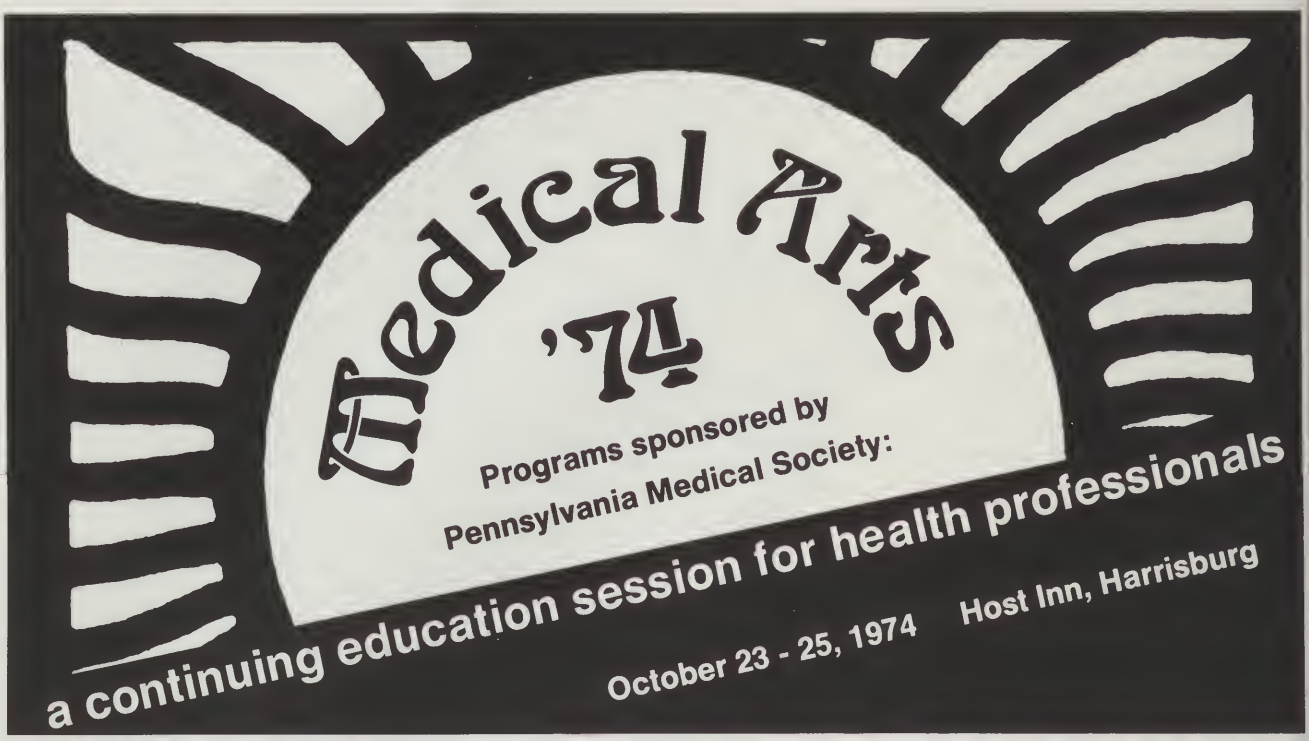

NOTE

If you are attending ANY of the programs sponsored by the Pennsylvania Medical Society PLUS a specialty society session, please send your registration to the Council on Education and Science, Pennsylvania Medical Society. The Council will forward the information to the specialty society. If you are registering ONLY for a specialty society meeting, send your registration as directed on the registration form on the facing page.

Wednesday, October 23, 1974

9:00 a.m. - 11:45 a.m.—Specialty Society Educators

Sharing session for chairmen of continuing education committees of specialty societies. Short reports on activities in continuing education of each specialty followed by questions and discussion.

12 noon - 1:30 p.m.—General Luncheon—Fee:$5.

"Liquid Crystals in Living Systems" Glenn H. Brown, Ph.D., Director of Liquid Crystal Institute and Regents Professor, Kent State University.

1:30 p.m. - 5:00 p.m.—"An Overview of Acupuncture"—Fee: $10.

Delineating for the physician the limitations in the use of acupuncture; providing the physician with sufficient background so that he may respond and answer inquiries by the lay public as to acupuncture's potential for pain control.

1:30 p.m. - 5:00 p.m.—Pennsylvania Council on Graduate Medical Education

Meeting of Directors of Medical Education of Pennsylvania hospitals. Topics include discussion of legislation of interest, practice management workshops for new physicians, the "end of the internship" and funding for graduate medical education.

Thursday, October 24, 1974

8:00 a.m. - 10:30 a.m.—Second Annual Prayer Breakfast—$4.

"Role of Religion in Health Care" Granger Westberg, D.D., Director of Wholistic Health Centers, University of Illinois.

Thursday and Friday, October 24 and 25, 1974

9 a.m., Thursday to 12 noon, Friday—"The Physician, the Patient, and Long-Term Care"—Fee: $30.

To assist the practicing physician understand his role in the management of long-term care patients; to identify for the physician, the long-term care facility administrator, and staff a relationship between each other so that effective living for individual patients is accomplished.

For complete program outlines of any of the sessions, contact:

Council on Education and Science
Pennsylvania Medical Society
20 Erford Road
Lemoyne, Pa. 17043

Medical Arts '74

October 23 - 25, 1974 **Host Inn, Harrisburg, Pa.**

Preregistration Form

Name: _____

Address: _____

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Member:

_____ PMS

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(name of specialty society)

_____ nurse

_____ student (_____ medical _____ nurse)

_____ resident

_____ intern

_____ other (specify) _____

Registration for:

_____ ACUPUNCTURE—Oct. 23, 1:30 - 5 p.m.
Fee: $10

_____ LIQUID CRYSTALS LUNCHEON—Oct. 23
Fee: $5

_____ LONG TERM CARE—Oct. 24-25
Fee: $30

_____ PRAYER BREAKFAST—Oct. 24
Fee: $4

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Mail to: Council on Education and Science • 20 Erford Road • Lemoyne, Pa. 17043

__ Registration for Hahnemann Medical College Seminar on "Physician's Assistant"—Fee $20 before Sept. 20, $25 thereafter.

Make check payable to:
Hahnemann Medical College and Hospital

Mail to:
Dept. of Medicine, 230 N. Broad St.,
Philadelphia, Pa. 19102.

__ Registration for Annual Meeting of Pennsylvania Orthopaedic Society, October 24, 25.

Mail to:
John B. Blakley, M.D., President
1 Allegheny Sq., Allegheny Center,
Pittsburgh, Pa. 15212.

__ Registration for meeting of the American Association of Medical Assistants, Oct 25—Fee (includes lunch) $8 for members, $15 for nonmembers.

Make check payable to:
A.A.M.A., Pennsylvania Society

Mail to:
Jane Ireland, CMA-A,
4032 Watters Lane, Gibsonia, Pa. 15044.

__ Registration for meeting of Pennsylvania Academy of Physical Medicine and Rehabilitation, Oct. 25.

Mail to:
Leon Reinstein, M.D., Secretary-Treasurer,
Thomas Jefferson University, Eleventh and Walnut Sts., Philadelphia, Pa., 19107.

__ Registration for meeting of Pennsylvania Psychiatric Society, Oct. 25.

Mail to:
Mr. Donald McCoy, Executive Secretary,
Pennsylvania Psychiatric Society, 20 Erford Rd.,
Lemoyne, Pa. 17043.

__ Registration for meeting of Robert H. Ivy Society, Oct. 25.

Mail to:
William P. Graham, III, M.D., Division of Plastic Surgery, M.S. Hershey Medical Center, Hershey 17033.

__ Registration for meeting of Pennsylvania Chapter of the American College of Surgeons, Oct. 25.

Mail to:
Lewis Patterson, M.D., Secretary, Central Pennsylvania Chapter, American College of Surgeons,
Polyclinic Hospital, Harrisburg, Pa. 17110.

Hershey-Medex update

Assistants' training program seeks preceptors

The Medex-Pennsylvania Program sponsored by the Department of Family and Community Medicine at the Milton S. Hershey Medical Center reached a developmental milestone with the graduation of the first class of Medex trained in Pennsylvania on August 7, 1974. An additional thirty-four Medex are in training with their physician preceptors. Twenty-nine of the physicians providing this training are Pennsylvania physicians, predominantly family physicians.

The Medex concept of primary care physician assistant training and deployment was originated in the State of Washington. Initially Medex programs were limited to ex-military corpsman but the concept has been expanded to include other trained health workers with experience in patient care and a desire to expand their role in this area. Medex programs have been particularly successful in the placement of Medex with physicians in rural areas and other areas of medical need. Benefits to the participating physician include a more flexible, more satisfying practice.

The Medex-Pennsylvania Program is fifteen months in duration. Following a didactic program at the Hershey Medical Center the student is trained by the preceptor in the practice setting. While developing his skills, the trainee also adapts to the preceptor's practice.

The Pennsylvania MEDEX program at The Milton S. Hershey Medical Center of The Pennsylvania State University graduated its first class August 7 and is seeking preceptors for its fourth class of 25 students to begin in January 1975.

In addition to the first 15 graduates, the Medex Pennsylvania program has enrolled 34 students who are in training with their physician preceptors in communities throughout the state at the present time.

The training program conducted by the department of family and community medicine is 15 months long. Three months are spent at the Hershey Medical Center in classroom and clinical instruction, followed by 12 months of clinical experience with a preceptor in the practice setting. The preceptors are selected first. They then spend a weekend at Hershey interviewing groups with twice the number of candidates as there are openings in the class. The preceptors then make the final selection of students they wish to be matched with. The goal of this is to have a matching of student and preceptor during the training period that will lead into a permanent employment relationship. This prematching for job placement is considered one of the advantages of the Medex type training program of physician's assistant.

Dr. Thomas L. Leaman, professor and chairman of family and community medicine, said, "we are seeking physicians who are interested in increasing their capacity to provide medical service, willing to serve as preceptors while paying the student to help provide medical care and committed to employ a Medex upon completion of training if economics and compatibility are favorable."

Physicians selected to serve as preceptors receive clinical appointments on the faculty of the department of family and community medicine.

Physicians interested in possible participation as a preceptor should contact Dr. Rugh Henderson, director, Medex Pennsylvania, The Milton S. Hershey Medical Center, Hershey, Pa. 17033.

M.D. offices excluded in regulations for state's new clinical laboratory act

(Continued from page 11)

council and directed the chairman of the board to write to the Secretary of Health citing the lack of statutory authority for the regulation and the threat it imposes to physician-patient confidentiality.

To prevent unethical advertising, all ads must be reviewed by the department prior to publication. No laboratory may advertise services which are not performed on its own premises, and advertising to the general public is prohibited.

Laboratories located outside the Commonwealth may do business here if they have a current valid license.

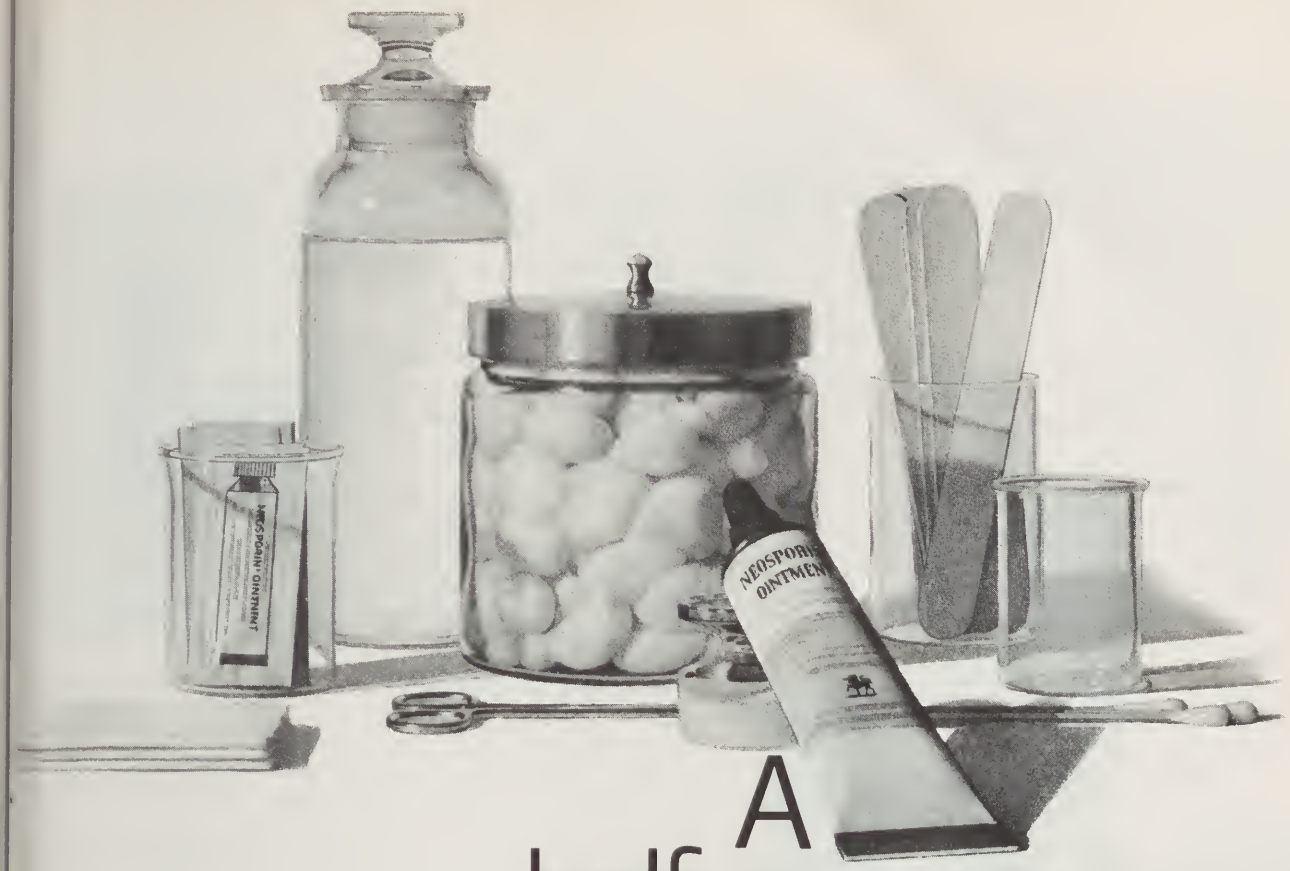
The department's powers of suspension and revocation come into play "for failure to maintain proper standards of accuracy, for unethical practice, unethical advertising or for any other cause deemed adequate by the department including failure to render required reports within the reasonable time limit set."

Among the prima facie causes for revocation are:

"Permitting unauthorized persons to perform the technical procedures or to sign reports.

Dishonest reporting or consistant error based on faulty techniques.

Violations of any provisions of these regulations or of the statutes under which they are adopted."



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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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Complete literature available on request from Professional Services Dept. PML.

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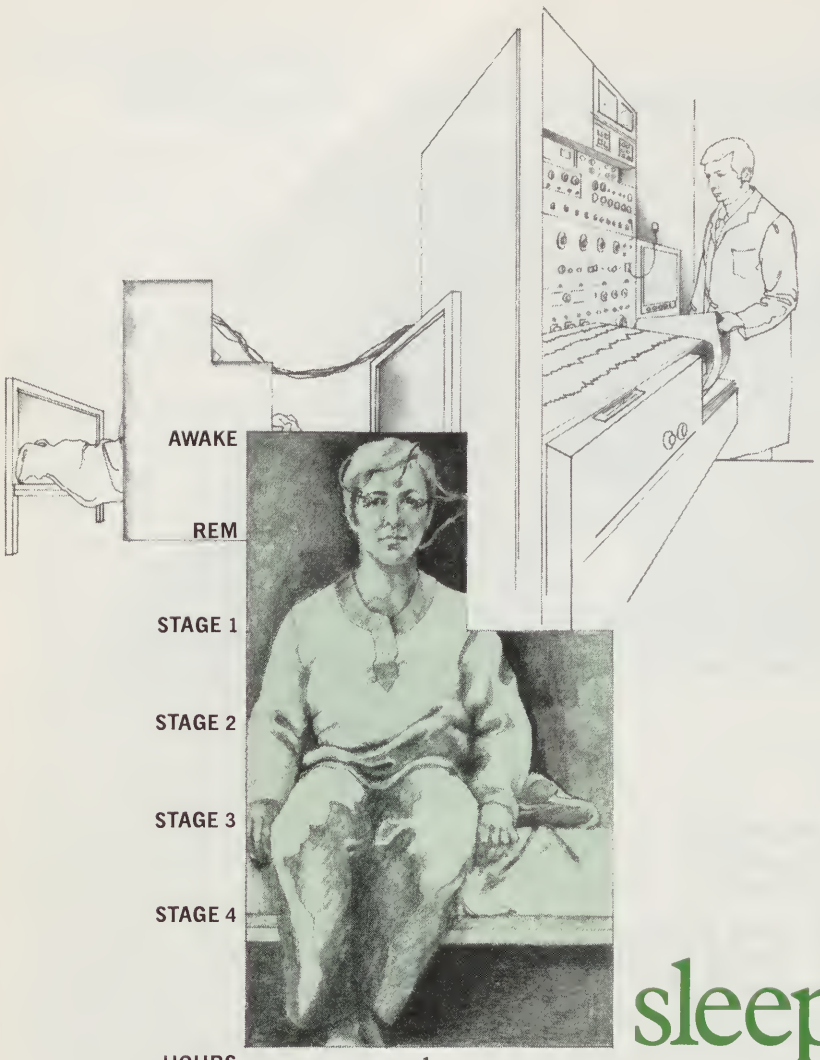

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proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

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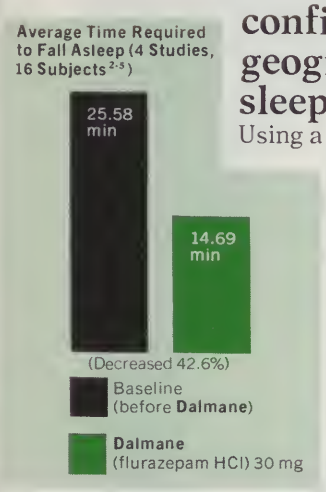

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

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Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
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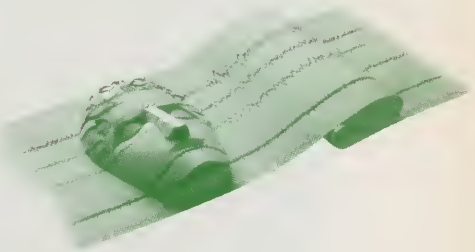

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Details, details, details

LEIF C. BECK, LL.B.
Bala Cynwyd

I hate to harp on an old subject, but a recent Federal Circuit Court decision has made it important once again to dwell on the importance of *details* in organizing and operating a professional corporation. The case, Epperson v. U.S. in the Seventh Circuit Court of Appeals (midwest), involved a surgeon who had incorporated but who had given virtually no attention to the formalities of corporate form. The net result was tax assessment of about $95,000, plus interest from the years 1962 through 1965, which was upheld upon a jury trial and then affirmed on appeal.

The government originally claimed that the corporation should be disregarded for tax purposes, thus taxing all its income including retirement contributions and other fringe benefit payments directly to Dr. Epperson. Later, however, the legal theory was changed to recognize the corporation's validity but to treat Dr. Epperson himself (not his corporation) as the "true earner" of the income. The effect of the change was to treat certain corporate payments to the doctor as *dividends* instead of as loans, a treatment which ended up even less beneficial than if the corporation had never been formed at all.

The judge's recital of facts to be considered by the *Epperson* jury reads like a list of what should or should not be done in operating a professional corporation. This list included: (1) Holding Board of Directors meetings where policy decisions are actually made; (2) setting salary scales and duties of employees, including the professional employee(s); (3) entering contracts with patients, suppliers, hospitals, etc. as a corporation; (4) notifying suppliers of the corporation's existence; (5) owning or renting property (including office space) as a corporation; and (6) having the right to control and direct the professional employee(s) as to corporate activities.

While some people might disregard the decision as being an obvious one involving an extremely badly managed corporation, I have seen far too many medical corporations here in Pennsylvania which are practically as bad. The physicians' plights in these cases have typically been that no one has pressed them to respect and carry out those details. As a result, I hope this article will point out to the incorporated or incorporating physician the importance of the details and of engaging advisors who will insist on them.

Epperson's Effect

The *Epperson* case is the second decision to have pierced the professional corporation's veil and directly taxed the physician. The first one, *Jerome J. Roubik,* occurred over four years ago, and the absence of any court action in between may have lulled many advisors into a false sense of security. Both cases, however, stand for a principle which is above doubt—a professional corporation can lose the desired tax benefits if its owners and advisors fail to give it ongoing attention. The advent of the new case not only confirms this fact but it may preview a trend. As stated in the Research Institute of America's tax service: "With this victory under its belt the Internal Revenue Service may now embark on a broader campaign against professional corporations. The threat is becoming stronger."

On the other hand, both of those decisions as well as the Internal Revenue Service's (IRS) published rulings confirm that a properly organized and operated professional corporation *will* be accorded that status for tax purposes. Pennsylvania's Professional Corporation Law is recognized as sufficient by the IRS, and it is in fact an excellent statute. Even one-man corporations, which many feared could not stand up to IRS scrutiny, have avoided being singled out for attack.

Actual Tax Audit Outlook

What have been the experiences of those professional corporations which have actually been subject to tax audits? Surprisingly few have been audited so far, and the audits have not usually been severe. This continues to be partly explained by the relative paucity of tax audits generally, with the IRS having been badly undermanned, a situation which seems to be changing as agents return from wage-price control work and as new IRS hiring seems to be adding to their staff size.

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On the other hand, corporations seem to have been undergoing somewhat more careful and sophisticated agent questioning, recently. The auditors are more regularly reviewing corporate minute books, checking documents against actual facts, looking for corporate indicia, etc. Armed with the new court decision, I believe such investigations will (and really should) increase hereafter.

The net effect of such background should be obvious. No one wants his corporation or his tax return to be vulnerable to IRS attack. Careful attention to the details of one's professional corporation is thus like an "insurance policy" against lost tax benefits, while ignoring them is equivalent to gambling with those desired tax savings. And, as shown by *Epperson*, losing a corporate audit can result not only in lost tax benefits but also in more taxes than if the corporation were never formed at all. Lack of care is simply a very risky proposition!

New Corporations

Even though the Keogh Act contribution limits are being raised to $7,500 (or 15 percent of one's net earnings), professional incorporation continues to be preferable for many practices. Assuming that a doctor or group has decided to incorporate, the actual attention to initial details depends in large part upon his or its attorney's diligence. This seems to vary widely.

Many attorneys seem to feel that their role should be limited to the legal *formation* of the corporation and the drafting of the few formal legal documents involved (bylaws, employment agreements, stock purchase agreements, and perhaps the retirement plans). Their fees for this work should be relatively minimal since these materials truly are quite routine in most cases. Lawyers following this approach meet only once or twice with their new corporate clients during the entire first year of existence, offering little in the way of detailed leadership.

I believe, however, that the attorney's role for a new corporation should be far more extensive. It should require his meeting with the doctor or group at least four and perhaps as many as eight times in the first corporate year. He should be directly concerned with whether all details are in fact accomplished, and he should insist upon their accomplishment. He should also provide regular counsel during that year, including consideration as to the retirement plan and other fringe benefit details. He should not abdicate responsibility in that area to a so-called pension or benefit consultant who too often has a sales interest in the client's decision. Finally, the attorney should assure that the corporation *ends* its year on a proper financial basis; for if attention is not given in the eleventh and twelfth months, there could be considerable economic loss.

These aspects of an attorney's undertaking need not especially demand someone who has created scores of professional corporations. They simply require his commitment to give his client plenty of time and honest advice. For this he should be entitled to a legal fee commensurate with the hours spent *in person* with his client, not just with the amount of paper produced by his automatic typewriter or photocopy machine.

I believe that a new corporation "checklist" can be a useful means for the client, attorney, and accountant to be assured that all initial details have been handled. We use a three-page checklist which assigns responsibility for each detail and which has a column for noting if and when the detail has actually been taken care of. A professional corporation's lawyer should not be satisfied that his client is properly in existence until all the checklist items have been completed and accounted for.

Existing Corporations

An all too common situation seems to be for an initially well-created corporation to receive less and less attention as it ages. Corporate minute books, which IRS agents really do check in most tax audits, tend not to be updated; changes in doctors' salaries tend not to be confirmed in employment agreements; auto and other professional expenses are handled differently than authorized; etc. This trend away from corporate attentiveness has proven difficult for several reasons.

First, of course, an IRS audit is concerned with *ongoing* operation. It will focus more on the facts as they have developed than on the initial corporate steps. Therefore, the risk of tax disqualification is not decreased simply because the first year of corporate life has passed.

Perhaps even more important, however, is a situation not directly tied just to tax audits. An alarming number of incorporated medical groups have found themselves enmeshed in complicated and/or embarrassing inter-doctor situations after several years of inattention. This has led some corporate advisors to say their activities are shifting more towards "straightening out" existing corporations than in guiding new ones.

These concerns have led some medical practices to arrange for periodic professional corporation reviews by a person or organization not regularly involved with that practice. Such "outside audits" are a means of assuring that details have not slipped by and of providing independent advice on developing problems. They are not intended to suggest lack of confidence in the group's regular team of advisors, but rather they demonstrate a desire to assure that the corporate step will remain as trouble-free and beneficial as originally anticipated.

Summary

At any rate, professional corporations generally seem to be proceeding smoothly with no new problems. The risks popularly described several years ago continue to exist, and they are confirmed by the *Epperson* case. However, the risks can be dramatically reduced simply by attention to detail and good interaction with the practice's attorney and other advisors. If the physician or group should be incorporated at all (and many should not), the advantages of that step certainly justify that degree of concern.

Trends in sex therapy—the Philadelphia plan

GERALD A. MELCHIODE, M.D.
Philadelphia

The purpose of this paper is to outline an approach to patients with sexual problems that will guide the general physician in management and to define the qualifications of a sex therapist.

As more and more patients are requesting therapy for sexual problems, the need to clarify the present role of sex therapy and to provide the physician with a sensible approach to the patient who presents with such problems has become evident. Since the publication of *Human Sexual Inadequacy* by Masters and Johnson in 1970, a variety of people have seen themselves as sex therapists and have treated many patients with little more background than familiarity with the book or attendance at a two day workshop. The title of "sex therapist" is not a professional title, and anyone can call himself this without any prior education. Consequently, many patients have subjected themselves to treatment that was often harmful. The purpose of this paper is to outline an approach to patients with sexual problems that will guide the general physician in management and to define the qualifications of a sex therapist. There follows a description of an organization that grew out of the medical schools of Philadelphia for the purposes of identifying abuses in the field and also for the purposes of sharing information concerning sex education and sex therapy.

Initial Evaluation

The physician should obtain a complete sexual history in order to evaluate the patient with a sexual complaint properly. This presupposes a solid foundation in both normal and abnormal sexual functioning at various ages. It is important that this history be obtained with the same objectivity as that used in obtaining a history for a respiratory illness. In all likelihood, if the physician is not a recent graduate and has not had a course in human sexuality that is currently being offered in most medical colleges, he will have no more formal knowledge about the subject than his patient. Also, he must be able to do a thorough physical examination or have someone available who can perform such an examination. If for some reason the physician cannot meet any of the above requirements, he should refer his patient at this point.

Diagnosis

If the male is affected primarily, the diagnosis is impotence, premature ejaculation, or ejaculatory incompetence. Impotence itself is further subdivided into primary impotence or secondary impotence. Primary impotence has been defined as a male never able to achieve and/or maintain an erection quality sufficient to accomplish successful coital connection either heterosexually or homosexually. Secondary impotence refers to the man who was at one time able to maintain an erection for successful intromission but is now unable. Masters and Johnson have defined the premature ejaculator as a man who cannot control his ejaculation for a sufficient length of time during intravaginal containment to satisfy his partner in at least 50 percent of their coital connections. Ejaculatory incompetence (which can be either primary or secondary) is defined as inability to ejaculate intravaginally.

If the woman is affected primarily, the diagnosis can be orgasmic dysfunction, dyspareunia, or vaginismus. Primary orgasmic dysfunction in the female does not parallel primary impotency in the male since primary orgasmic dysfunction precludes any orgasmic attainment throughout her entire life even

'The need to clarify the present role of sex therapy and to provide the physician with a sensible approach to the patient who presents with such problems has become evident.'

through manipulation. Dyspareunia can be defined as painful intercourse, and this diagnosis can also be made in the male. Vaginismus refers to spastic contraction of all the pelvic muscles around the perineum and outer third of the vagina.

If the physician finds that he is not knowledgeable about these clinical entities, referral should be made at this point.

Etiology

Before a treatment plan can be devised, the etiology of the sexual dysfunction must be established. Causes of sexual problems fall into two main categories—organic or functional.

Two clinical entities that are always functional are vaginismus without accompanying pain and premature ejaculation. Although the vast majority of sexual problems are psychogenic, any organic causes must first be ruled out. This would presuppose that one had a thorough grasp of the physical causes that could precipitate a sexual problem. An example would be impotency caused by the visceral neuropathy found in diabetes or as a side effect of Mellaril® (Sandoz Pharmaceuticals). After a thorough history and physical examination to rule out organic causes, the functional etiologies should then be considered.

Functional causes can be clinically divided into five categories. First there are sexual dysfunctions that are merely one facet of a much larger psychiatric syndrome; for example, the impotency that is a symptom of depression.

Secondly, there are those sexual problems that arise out of misinformation. An example would be the man who cannot feel any friction while having intercourse with his wife who has used two applicators full of spermicidal foam instead of one.

The third category consists of those dysfunctions that are learned or social. For instance, the woman who was brought up in a strict family where sexual topics were taboo and who subsequently cannot relax sufficiently during coitus to attain orgasm.

The fourth category of functional causes of sexual dysfunction would include those that arise from interpersonal conflict. An example is the man who is angry with his wife and who represses his rage, then finds that his anger is expressed through premature ejaculation.

The fifth group of psychogenic causes would be those that arise from intrapsychic conflict. A case illustrating this category would be that of a woman who has a dread of intercourse which is represented in her unconscious as a masochistic submission to a hostile attack.

Only when the clinician has decided on an etiology can he intelligently embark on a sensible course of treatment. The inability to arrive at a probable cause of your patient's sexual problem would indicate referral at this point.

Treatment

The therapy of sexual problems must be related to the etiology and tailored to the needs of the patient. The treatment for those difficulties arising from organic causes must obviously be aimed at removing the organic cause. The woman who complains of dyspareunia and is found to have endometriosis must be treated for the endometriosis.

Education is the best treatment for sexual dysfunction that results from misinformation. If sexual dysfunction is found to be a symptom of another illness, the clinician must treat the larger illness. An example would be the use of psychotherapy and antidepressants to treat the syndrome of depression causing loss of libido. Some sexual problems arise from causes that are learned or social. Masters and Johnson found that many men suffering from premature ejaculation had developed a pattern of ejaculating quickly which was reinforced by their culture. The most efficient method of treating a couple in which the man is a premature ejaculator is by using methods based on the Masters and Johnson technique. The relationship is a primary focus of intervention. The couple is helped to communicate more openly, and the husband and wife both participate in training the male to last longer. Masters and

Johnson claim a 98 percent cure rate.

Those problems that are the result of interpersonal conflict are treated best by a combination of couple therapy and direct intervention. A case in point would be a young woman who complains of dyspareunia. One of the most common causes of dyspareunia is lack of lubrication. In order to lubricate, the woman must be relaxed and relatively free of anxiety. This mechanism parallels erection in the male. Since the birth of the first child, the woman complains that her husband has been overly critical and demanding. The source of the husband's demands was found to be his feeling of having been neglected since the child was born. Instead of being openly annoyed at her husband's demands, she (feeling very dependent on him at the time) had buried her resentment only to have it manifested in her inability to relax and lubricate when they had intercourse. A case such as this usually responds well in the hands of an experienced couple or family therapist who has a knowledge of the Masters and Johnson techniques.

The last group (and the most difficult to treat) are those sexual inadequacies that arise from intrapsychic conflict. A 43-year-old man presented with primary impotency. His few attempts at intercourse filled him with dread and ended in failures. In individual analytically oriented psychotherapy it was discovered that his mother suffered from tuberculosis. As a young child he was never permitted near his mother, always being warned by an aunt that something dangerous would happen if he got close to her. She died when he was four and at the height of his castration anxiety. The only time he was asked to kiss her was when she was layed out in her casket. This threw him into the most acute anxiety. Subsequently, women were represented in his unconscious as extremely dangerous. His symptom of impotency was not only a manifestation of his castration anxiety, but also it was an adaptation for him. Since he was impotent, he had an excuse for avoiding intimate relations with women and for avoiding the feared object. The best approach to these cases is a combination of insight-oriented psychotherapy and behavior modification along the lines of Masters and Johnson. If there is a partner available, such cases are best treated in couple therapy. There are those individuals who would not be satisfied with anything less than understanding the origins of their sexual difficulties, and for these patients I would recommend psychoanalysis.

The Philadelphia Plan

I have outlined an eclectic approach to the patient with sexual dysfunction and suggested guidelines for referring patients to a sex therapist. Who is a qualified sex therapist? A sex therapist should possess a knowledge of both normal and abnormal sexual functioning. He must be able to take an objective sexual history and do a psychiatric screening. He must be capable of arriving at a diagnosis of sexual dysfunction and determine the etiology. In order to determine the etiology, he must be aware of organic and psychogenic causes. His treatment should be related to the etiology and needs of his patients. He should be familiar with the techniques of direct intervention developed by Masters and Johnson and must also be familiar with basic principles of psychotherapy.

Dr. Melchiode is associate director of the division of education and training at Hahnemann Medical College and Hospital of Philadelphia. Colleges and Hospitals represented in the Philadelphia plan are Albert Einstein Medical Center, Eastern Pennsylvania Psychiatric Institute, Hahnemann Mental Health Center, Jefferson Community Health Center, Medical College of Pennsylvania, Temple University School of Medicine, University of Pennsylvania Marriage Council, and Crozer-Chester Medical Center.

If a physician does sex therapy himself or refers his patient to a sex therapist, and finds that the above requirements are not being met, then his patients are not receiving the proper treatment and in some cases treatment may actually be harmful. Because of the concern for the abuses in this field, a network of sex educators and sex therapists who represent medical schools and major hospitals having such programs has been organized in Philadelphia.

The primary purpose is to encourage communication between therapists treating patients with sexual dysfunction. This is being accomplished by: exchange of scientific information, clinical conferences, locating and involving isolated therapists, etc.

The second goal of this organization is to encourage and facilitate collaboration in research and therapy between institutions represented in the organization and between individual members.

A third goal is to provide education for both professions and the lay public in matters pertaining to the treatment of sexual dysfunction and human sexuality in general.

The network is truly multidisciplinary and is composed of psychiatrists, gynecologists, urologists, and professionals within the mental health sciences. Treatment philosophies vary among the group—from strict behavior modification to a psychoanalytic approach. However, within these diverging viewpoints, a forum is being provided to learn more about this important aspect of human behavior that has been long shrouded in ignorance. □

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MIRIAM K. ELMALEH, M.D.
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Many physicians will undoubtedly react with skepticism to the appearance of a new anorexiant. However, the development of chemically distinctive compound mazindol, (Sanorex®, Sandoz Pharmaceuticals; 5-p-chlorophenyl-5-hydroxy-2, 3-dihydro-5H-imidazo [2,1-a] isoindole) for anorectic applications was of high interest, since it offered the possibility of obtaining amphetamine-like efficacy without the customary problems related to central nervous system stimulation and increasing dosage requirements.

A review of preclinical and limited clinical studies demonstrated that further investigation of mazindol was warranted, particularly because of the low-milligram dosages employed and indications of pharmacologic and chemical uniqueness. As a result, a controlled trial was conducted with patients having simple obesity. The primary purpose was to determine this compound's efficacy and safety, in conjunction with caloric restriction, when compared with a placebo. We hope that our findings and interpretations will be of assistance to physicians considering a new product for obesity, a condition which is often refractory to treatment.

Material and Method

Patients who were at least 15 percent overweight (determined from standard weight tables of the Metropolitan Life Insurance Co., 1966) and whose obesity was unrelated to endocrine, cardiac, or metabolic causes were screened from a private practice. Thirteen men and forty-seven women aged eighteen to sixty-six years were selected who appeared emotionally stable and motivated to participate in a weight-reduction program; were essentially of good health and did not require significant concomitant medication; had not received anorectic drugs within the previous six weeks; and among the women, were neither pregnant nor lactating.

Patients were randomly assigned to two groups of forty and twenty persons. For twelve weeks the forty-patient group received 2 mg tablets of mazindol (one tablet per day taken one hour before lunch), while the twenty-patient group received placebo tablets (also one tablet per day before lunch). In compliance with double-blind procedures, the active and placebo tablets were matched in appearance and packaging so that neither patients nor staff knew the identity of the tablets being administered to any one person. Both treatment groups were also advised to follow a 1000 calorie diet for the duration of the trial and were given menu suggestions and other information regarding food values.

All patients were seen at two-week intervals during the trial for evaluation and recording of data on treatment efficacy and safety. At an initial pretrial visit, background information (e.g., age, sex, duration of obesity), the results of physical and ophthalmoscopic examinations, and vital signs (body weight, blood pressure, pulse) were recorded, and a two-week supply of the assigned medication was provided to each patient. In an effort to evaluate the reliability of skinfold thickness as an indicator of change in body adiposity, data on each patient's triceps and subscapular skin-fold thickness were also recorded at the pretrial visit. (Choice of this parameter was prompted by a favorable 1965 report by Montoye, Epstein, and Kjelsberg.[1]) At two-week

evaluation agent in obese adults

'After twelve weeks, weight reduction achieved with this agent adjunctive to caloric restriction was at least five times that achieved with a comparable regimen of placebo and dieting.'

intervals thereafter during the trial, patients returned for successive drug supplies, and data on their vital signs and the nature and severity of adverse reactions were recorded. The latter information was obtained in interviews with the patients regarding any effects of medication they perceived and the spontaneity of their comments or complaints. At the sixth and final visit (the twelfth week), follow-up physical and ophthalmoscopic examinations and skinfold thickness measurements were also performed.

By the conclusion of the trial, data on ten of the original sixty patients were eliminated because of six dropouts due to side effects, two due to treatment failure, one because of relocation of household, and one because of concomitant medication with a diuretic agent. Thirty-three patients received mazindol and seventeen a placebo. As shown in Table I, they formed comparable study samples.

Data on these fifty patients were analyzed with appropriate statistical procedures to test homogeneity of the study samples and treatment effects as follows: (1) background variables—analysis of variance and nonparametric tests; (2) body weight and other vital signs—analyses of variance and covariance, t-tests, and trend analysis based on body-weight "difference scores" calculated for each patient*; and (3) physical and ophthalmoscopic examinations and adverse effects—nonparametric tests. Results of statistical inference tests were declared significant at $p<0.05$.

TABLE I

Characteristics of Study Samples (no significant differences)

	Mazindol group	Placebo group
Number of patients:		
Men	6	5
Women	27	12
Total	33	17
Age (average, yrs.)	40.0	39.3
Weight (average, lbs.)	175.5	177.5
Ideal weight (average lbs.)	133.7	136.9
Percentage Overweight	30.1	29.4
Duration of Obesity (average, yrs.)	9.4	7.3

Results

Tables II to IV summarize the key findings of the trial regarding the weight-reduction effects of mazindol in relation to placebo. As Table II shows, treatment benefit was greater for the mazindol than the placebo group after twelve weeks. Seventy-six percent of those given mazindol lost weight, com-

"Difference scores" = weight at weeks 2,4,6,8,10, and 12 each less the week 0 weight. The average group "difference score" was derived from the weight change of all patients in the group for each rating period.

TABLE II

Results of 12-Week Treatment with Mazindol and Placebo

Treatment Response	Number (%) of Patients	
	Mazindol, 2 mg per day	Placebo
Lost Weight	25 (76%)	9 (53%)
Weight Unchanged	2 (6%)	0 (-)
Gained Weight	6 (18%)	8 (47%)
	33 (100%)	17 (100%)

TABLE III

Comparison of Average Weight Reduction Throughout 12-Week Trial: Mazindol vs Placebo

Week of trial	Average Weight Loss *Compared to Baseline (lb.)*		Difference in favor of Mazindol (lb.)
	Mazindol 2 mg/day	Placebo	
Pretrial Average Weight	175.36	177.53	
2	2.24**	1.18	1.06
4	3.52**	1.06	2.46
6	4.21**	1.41	2.80
8	4.79**	1.18	3.61*
10	5.06**	1.71	3.35
12	4.94**	0.88	4.06*
Week 12 Average Weight	170.42	176.65	

*$p < 0.05$
**$p < 0.01$

pared to 53 percent of those on placebo. Also, while 47 percent of those on placebo gained weight, only 24 percent of the mazindol group either lost no weight or gained. As was mentioned previously, only two patients, one in each group, were considered treatment failures. Both reported an increase in appetite and were dropped from the trial after six or eight weeks. Their data were excluded from the analyses.

Considering the actual weight change realized by patients in both groups, the anorectic effects of 2 mg mazindol once a day proved to be statistically significant (Table III). In relation to their average pretrial weight, mazindol treated patients showed a significant average weight loss throughout the twelve-week trial. In contrast, the average loss of placebo treated patients was not significant at any point during the trial. Comparison of the average weight losses for both groups favored mazindol over placebo at each biweekly rating, with this difference being significant at weeks eight and twelve. In fact, weight loss on mazindol averaged about two and a half times greater than that achieved with placebo during the first half of the trial and about four and two-tenths times greater during the second half.

Trend analyses confirmed that the overall pattern of weight loss for the mazindol group was significantly linear. Thus, weight reduction with mazindol was achieved at

a rather uniform rate throughout the twelve-week period. No significant trends of weight change were detected for the placebo group, however. Consequently, by the end of the trial, average weight of the mazindol group was reduced 4.9 lb. compared to 0.9 lb. for the placebo group.

Because of clinical emphasis given to the effects of short-term therapy with anorectic agents, it was desirable to examine data obtained from the first six weeks of treatment (Table IV). At this midpoint of the trial, only 19 percent of the mazindol group (but more than twice this percentage of the placebo group) had either failed to lose weight or showed a gain. On the other hand, optimal weight reduction was realized by 31 percent of the mazindol group compared to 24 percent of those on placebo. These patients lost at least 6 lb., or an average of 1 lb. or more per week. The remaining patients who did benefit after six weeks of treatment (50 percent of the mazindol and 35 percent of the placebo group) lost from 1 to 5 lb., or less than 1 lb. per week, on average. In terms of the actual weight change after this short six-week course of trial, mazindol treated patients lost 4.21 lb. on average, while placebo treated patients lost one-third as much or 1.41 lb.

The use of skinfold measurements for an objective indication of changes in body adiposity proved to be of no real advantage since the pretrial vs twelve-week data on this parameter were inconclusive. On the one hand, the reduction in triceps skinfold thickness was significant (from 27.5 to 26.3 mm) for the mazindol group but not for the placebo group (from 25.8 to 25.6 mm). Changes in subscapular thickness were insignificant for both groups, and for neither measurement were differences between the groups significant.

Data obtained from physical and ophthalmoscopic examinations, pulse and blood pressure measurements, and the evaluation of adverse reactions indicated no clinically significant differences between patients given mazindol or placebo. For example, with mazindol, side effects (primarily mild and transient nausea, headache, "bad taste," or nervousness) were recorded for twelve of the forty patients in this group at the start of the trial. The side effects were considered drug-related for six of these

TABLE IV

Short-term Treatment Results: Weight Change on Mazindol and Placebo After Six Weeks

Lbs./Week	Percentage (No.) of Patients: Mazindol group	Placebo group
Lost		
>1	31.2% (10)	23.5% (4)
0.5 - 0.9	18.8% (6)	11.8% (2)
0.1 - 0.4	31.2% (10)	23.5% (4)
0	9.4% (3)	11.8% (2)
Gained		
<0.5	9.4% (3)	29.4% (5)
Total	100% (32)*	100% (17)

6-week data on one patient were not complete.

'In the light of the controversy about amphetamines, an effective nonamphetamine like mazindol cannot be ignored. . . Safety parameters indicated the active drug was well tolerated and without potential health hazards.'

patients, but only two of them (experiencing headache, nausea, and nervousness,[1]) had to be withdrawn from medication. For the remaining six patients on mazindol, the side effects could not be related to the drug with certainty, but three of these patients were also withdrawn from treatment. Among the original twenty patients given placebo, one developed multiple side effects (depression, headache, lethargy, impotence) and was withdrawn from the trial. In this case the cause of such reactions could not be determined with certainty.

Discussion

Like others [2-4] who have studied the clinical usefulness of mazindol, the author found it both safe and effective as an anorectic agent. After twelve weeks, weight reduction achieved with this agent adjunctive to caloric restriction was at least five times that achieved with a comparable regimen of placebo and dieting. The linear pattern of weight reduction noted for patients given mazindol also demonstrated rather consistent efficacy with the single 2 mg/day dosage over the twelve-week period, although more substantial weight loss tended to occur in the early weeks of treatment. The observation of continuous effect at one dosage level suggests that tolerance and the consequent need for increasing dosages are unlikely to develop with mazindol treatment. This may represent a distinct advantage over the use of amphetamine anorectics, which often results in rapid tolerance, increased dosages, and in some cases, progression to psychic dependence.

In this trial, as in the others, these findings regarding mazindol's efficacy were not compromised by results of a variety of safety evaluations. Generally mild drug-related side effects were encountered in six patients and for four of them the effects were short-lived. Since dosage changes were not permitted by the design of the trial, it is open to speculation whether discontinuance of mazindol was actually necessary in the remaining two patients with persisting side effects. Under normal clinical circumstances, the response to dosage reductions would indicate if these patients were, in fact, intolerant of the drug or else were amenable to lower-dosage treatment.

Two recent articles by Hadler[2] and Collipp et al[3] report on controlled studies of mazindol and placebo that are comparable in design to this study. In the first trial, 2 mg mazindol daily was administered to twenty-two adult patients for twelve weeks along with caloric restriction, while seventeen adults served as placebo controls. In the second trial, the same dosage was given to fifty adolescents under similar dietary conditions for twelve weeks, and placebo was given to forty-three adolescents. In both trials, cumulative weight loss achieved with mazindol was greater than with placebo (adults: 12.4 vs 8.8 lb; adolescents: 18.9 vs 11.8 lb.). In the adolescent trial this difference was statistically significant. As for safety, the conclusions generated by both trials were similar to the present one: mazindol appeared safe and relatively well tolerated. Thus, data available on the 2 mg/day dosage of mazindol confirm that it safely produces weight loss beyond that which can be attributed to motivational factors or placebo effect alone.

Overall, there are several features of mazindol which enhance its clinical usefulness. Its administration—one 2 mg tablet taken each day—is simple and quite acceptable to patients. Its consistency of effect at low-milligram dosages noted in this and other trials[2,3] and its apparent lack of excessive central nervous system effects indicate a low abuse potential as compared to the amphetamine-type drugs. In the light of the controversy about amphetamines, an effective nonamphetamine like mazindol cannot be ignored.

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Summary

Data are presented from a twelve-week controlled comparative study of mazindol, a new chemical entity, and placebo in sixty exogenously obese adults. At 2 mg daily, and in conjunction with caloric restriction, mazindol produced significantly more weight loss (4.9 lb.) than placebo and a comparable dietary regimen (0.9 lb) after twelve weeks.

Safety parameters indicated the active drug was well tolerated and without potential health hazards. Drug-associated side effects developed in six patients given mazindol, while multiple reactions of unknown cause were seen in one patient given placebo. In most cases, side effects were mild and transient. However, since dosage reductions were not permitted in the trial, three patients (two on mazindol, one on placebo) were withdrawn from treatment. Finally, from a brief review of recent clinical reports, the efficacy, safety profile, and potential clinical benefits of this nonamphetamine compound are discussed. □

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Electrocardiographic T-wave abnormalities accompanying severe hypoxia

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Patients presenting with prolonged hypoxia are occasionally encountered in all emergency rooms. We recently treated three patients who developed striking electrocardiographic T wave changes following hypoxia of diverse etiology. One patient had a "café coronary," another self-administered an overdose of narcotic, and the third received an overdose of meprobamate.

Case Reports

Case 1—M. M., a 65-year-old woman, developed a severe attack of choking while dining out on January 26, 1972. She collapsed, became cyanotic, and when seen in the emergency room twenty minutes later, was seriously ill. Her respirations were shallow and labored, pulse was 150 per minute and regular, and her blood pressure was 170/110.

Tracheal intubation yielded a large bolus of meat. Tracheostomy was performed, and more aspirated meat was removed. The patient was comatose, and ventilation was accomplished with a Bird respirator. Consciousness returned, and the patient made a smooth recovery in spite of the presence of an aspiration pneumonia.

On the day after admission, January 27, 1972, arterial pO_2 measured 57.5 mm Hg and the oxygen saturation was 91.5 percent. Electrocardiograms on January 26 and January 27 (Figure 1) showed nonspecific T wave changes, but the electrocardiogram of January 28 (Figure 1) showed T wave changes strongly suggestive of either cerebral or subendocardial damage. The serum levels of glutamic oxaloacetic transaminase (SGOT) and lactic dehydrogenase (LDH) were normal on January 29 and 30. Electrocardiograms showed improvement by February 5, 1972. During her hospital stay, the patient had no complaints of chest pain and did not develop cardiac complications.

A classical "café coronary" apparently resulted in hypoxia severe enough to cause a severe disorder in cardiac repolarization.

Case 2—R. D., a 16-year-old boy, injected himself with an unknown dose of morphine sulfate on February 20, 1972. This was followed by collapse and cyanosis; and when seen in the emergency room, he was comatose, cyanotic, and tachypneic. The pulse was 120 per minute and the systolic blood pressure was 110 mm Hg. Narcan,® (Endo Laboratories, Inc.), 0.2 mg, was given intravenously and tracheal intubation was performed. Recovery was uneventful. The initial electrocardiogram (Figure 2) showed only nonspecific changes in ST segments and T waves. On February 21, his second hospital day, the precordial T waves were inverted, and this became more pronounced on February 22 (Figure 2). Enzyme determinations are shown in Table 1. Subendocardial infarction was a possible diagnosis. Therefore, he was maintained on a modified bedrest program and did well. A final electrocardiogram showed improvement (Figure 2). He was discharged in good condition on March 8, 1972.

A narcotic overdose caused prolonged anoxia due to respiratory depression resulting in a T wave

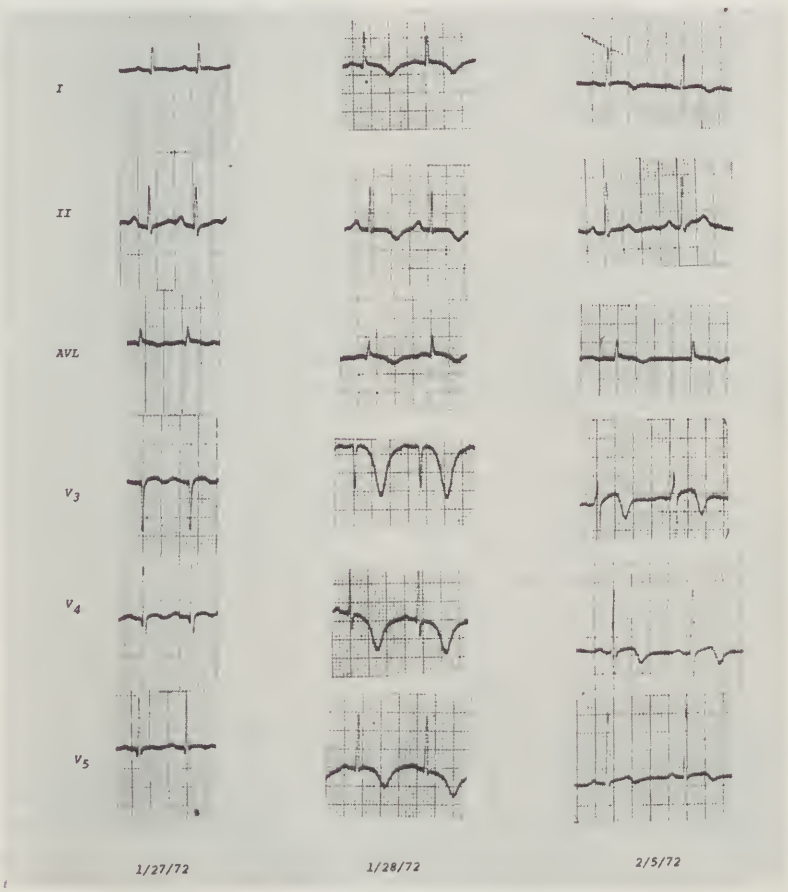

Figure 1. Serial electrocardiograms, patient 1.

pattern thought compatible with subendocardial damage.

Case 3—M. G., a 65-year-old female, was admitted on September 7, 1972. She was a known manic-depressive psychotic and alcoholic and was taking meprobamate daily. Her family noticed progressive lethargy and eventual collapse and brought her into the hospital. She was comatose, cyanotic, and without detectable pulse or blood pressure. An endotracheal tube was inserted and a Bird respirator with oxygen was used. Several hours later the pO_2 was 223 mm Hg. The level of meprobamate was 10 mgm/100 cc. Aramine® (Merck, Sharp and Dohme) was started and continued for forty-eight hours until the patient finally aroused and had normal vital signs. Serum enzyme results are shown in Table 2. An electrocardiogram taken August 4, 1969, is shown for comparison (Figure 3). The electrocardiograms of September 7 and 8 show a probable anterior superior block and nonspecific ST-T changes (Figure 3). On September 9 and 10 there was massive T wave inversion compatible with either cerebral damage or subendocardial necrosis (Figure 3). She, as the others, had no cardiac symptoms, made an uncomplicated recovery, and was discharged on September 22, 1972.

This patient is similar to Case Two. The patient took an overdose of meprobamate and was anoxic for a prolonged period. The T wave changes could have been the result of either cardiac or cerebral damage.

Discussion

Electrocardiographic T wave changes are nonspecific, often labile, and may be affected by a variety of "extra cardiac" factors such as cold, autonomic influences, position, electrolyte imbalance, drugs, and endocrine disorders.[1] More relevant to the cases reported are the T wave changes that have been noticed in a variety of cerebral disorders.[2-4] The question is whether the T wave changes noted in the three patients reported were evidence of cardiac damage or due to cerebral factors.

These patients were exposed to prolonged hypoxia, and it is known that as little as five minutes of severe hypoxia or anoxia can produce irreversible damage to the mitochondrial enzyme systems concerned with aerobic metabolism of the heart. Fifteen to twenty minutes can produce mitochondrial swelling, and after thirty to forty minutes distortion of mitochondrial structure occurs.[5]

Clinicians have made use of hypoxia as a test for angina pectoris by having patients breathe oxygen from mixtures which lower the pO_2 to near 70 mm Hg.[6] A positive test consists of the production of typical chest pain and/or electrocardiographic changes. ST-T wave changes appear to be the most sensitive index of myocardial damage.[7,8]

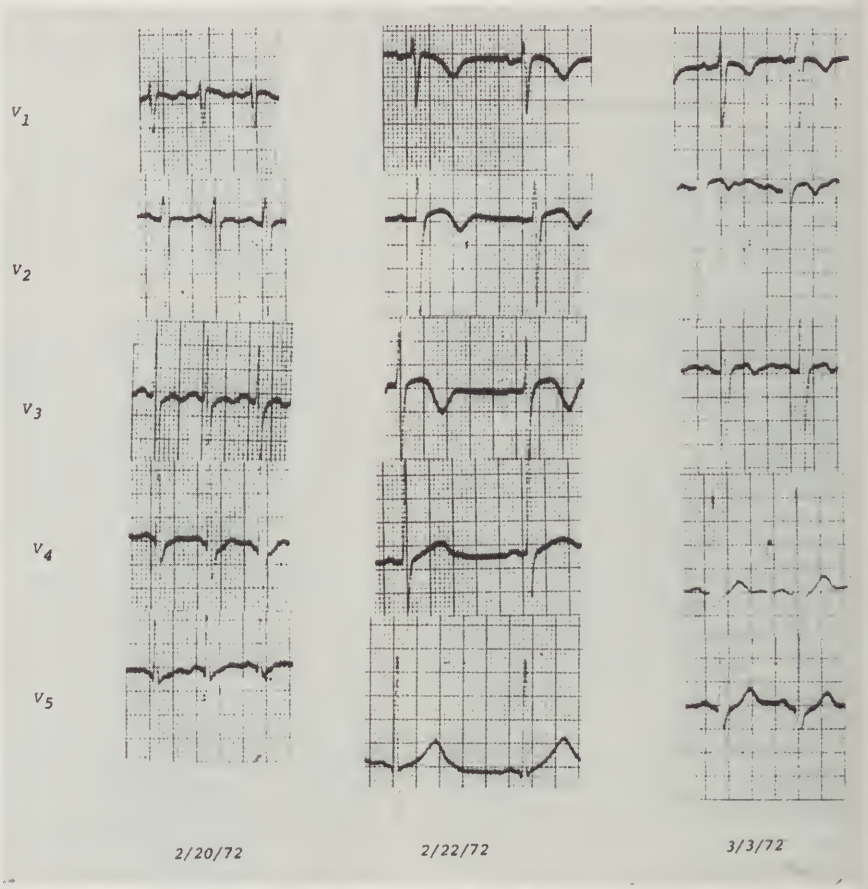

Figure 2. Serial electrocardiograms, patient 2.

TABLE I

DATE	SGOT	LDH	CPK
2/21/72	88	1176	
2/22/72	80	740	
2/23/72			257
2/25/72	38	408	
Normal	up to 40 u.	up to 50 u.	up to 50 u.

Serial serum enzyme changes in Case Two

TABLE II

DATE	SGOT	LDH	CPK
9/11/72	70	840	382
9/15/72	33	612	32

Serial serum enzyme changes in Case Three

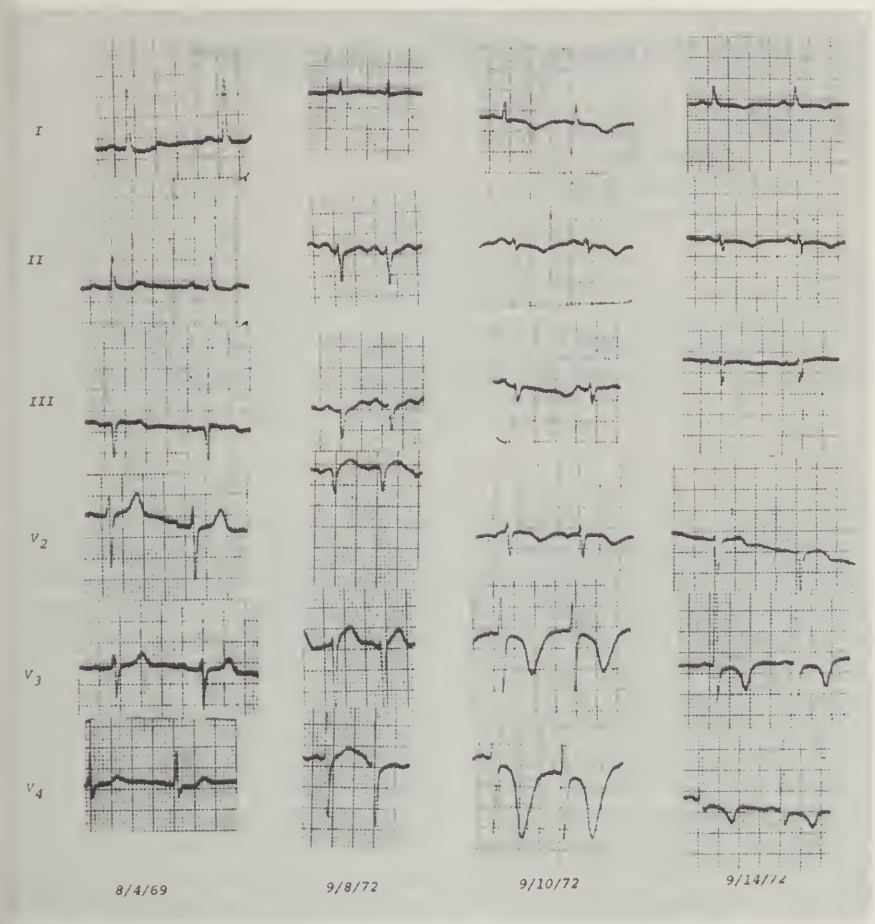

Figure 3. Serial electrocardiograms, patient 3. An electrocardiogram taken in 1969 is shown for comparison.

Both the first and third patients were 65 years of age and presumed to have coronary artery disease. Neither patient had clinical evidence to substantiate myocardial infarction, although there were serum enzyme elevations in the third patient. There was no way to definitely make a diagnosis in the second patient.

Thus, although it is possible that all three of these patients may have sustained myocardial damage, there is no firm proof of this. Further investigations such as coronary arteriography and left ventriculography were not performed.

An alternate explanation for the T wave changes is the "cerebral T wave syndrome." In 1962 Hugenholtz[2] reviewed the literature on this subject and discussed the QT prolongation and widely inverted T waves occasionally seen in association with cerebral disorders. He described these changes in patients with subarachnoid hemorrhage, metastatic brain tumors, and cerebral embolism and thrombosis. Other possible mechanisms for the T wave changes were excluded. Hersch[3] reported T wave changes in 15 to 20 percent of patients with either subarachnoid hemorrhage, meningitis, or intracranial space-occupying lesions. The orbital surface of the frontal lobe (area 13) has been incriminated as the cerebral controlling factor, and this area has been described as the cortical representation of the vagus nerve.[4] Stimulation of this area has produced the typical ECG changes.[2] Other work indicates that hypothalamic irritation can cause distortions in the T waves.[9]

A dissenting point of view is expressed by Koskelo and his coworkers[10] who feel that the T wave changes seen in association with intracranial bleeding result from true subendocardial damage caused by reflex hypertension and prolonged vagal stimulation.

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Conclusion

Three patients are presented who manifested electrocardiographic T wave changes following bouts of severe generalized hypoxia. In two, this occurred secondary to drug overdosage; and in the third, the mechanism was a foreign body in the trachea. In two of the three patients the electrocardiographic changes were accompanied by transient serum elevations of glutamic oxaloacetic transaminase and lactic dehydrogenase. The changes suggest the occurrence of myocardial damage secondary to the generalized hypoxia. One cannot, however, rule out the possibility of T wave changes of a "cerebral" origin. □

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Hemophilia and the Pennsylvania Program

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This is the first of a series of articles which PENNSYLVANIA MEDICINE will publish on hemophilia, including: emergency room care, home treatment, problems in children, orthopedic problems, inhibitor in hemophilia, and hepatitis in hemophilia.

HEMOPHILIA is defined as an "hereditary hemorrhagic diathesis characterized by hemarthroses and deep tissue bleeding, due to deficient generation of intrinsic thromboplastin."* The term hemophilia now is used to cover any plasma coagulation factor deficiency which is associated with bleeding symptoms. This includes classic hemophilia. These disorders are hereditary in the sense that they are genetically controlled, but many patients are seen who know of no other bleeders in generations past.

Table I lists the International numbering system for coagulation factors and some synonyms.

Table II lists the coagulation factors deficiencies or abnormalities which have been identified, their inheritance patterns, and the estimated incidence per million. The population of Pennsylvania is about 12 million; therefore, we can estimate that over 2,000 bleeders live in our state. Note also that deficiencies of VIII and IX are by far the most common of the heritable bleeding diseases.

Each individual with hemophilia is born with the disease, and it lasts throughout his life. It might be likened to a Sword of Damocles constantly threatening severe, even fatal, hemorrhage. The defect may be mild or very severe, and the clinical picture and need for treatment vary accordingly. Most commonly, hemorrhages follow some form of injury, but they may also appear without known cause.

The most common clinical manifestations are easy bruising, bleeding from the kidneys, bleeding into the joints, and excessive bleeding following injuries or operations. Bleeding into the joints, acute hemarthrosis, is very painful but responds well to fraction therapy if treatment is started early. When hemarthroses are ignored or there are repeated episodes in the same joint, a crippling arthritis may develop. The loss of many days from school or work and long, costly periods of hospitalization have been common.

Normal plasma factor concentrates are now available for replacement therapy, and it should be possible for almost all hemophiliacs to receive treatment which prevents the pain, crippling, loss of time from school or work, and expense of frequent hospitalizations. It is also hoped that with regular fraction therapy, older patients will be able to improve joint function with physical therapy to reconstructive surgery. Replacement plasma factor therapy is expensive, and adequate treatment has been, until recently, beyond the financial means of many patients.

Therapy is accomplished with plasma factor concentrates or fractions. These are available for factor I deficiency (Fibrinogen,® Hyland Division, Travenol Laboratories, Inc.). Concentrates for use in factor VIII or IX deficiency are listed in Table III. One unit represents the amount of factor in one ml of fresh normal plasma. Dosage should be calculated by the manufacturer's stated units printed on the bottle label. The exact dosage will be discussed in detail in later articles on emergency care and home treatment. Suffice it to say here that the

Dorland's Illustrated Medical Dictionary. 24th ed., Philadelphia, W. B. Saunders Co., 1965, p. 663.

TABLE I

Coagulation Factors

I	Fibrinogen
II	Prothrombin
III	Tissue Thromboplastin
IV	Calcium
V	Proaccelerin, Labile Factor, Ac Globulin
VI	Not Used
VII	Serum Prothrombin Conversion Accelerator (SPCA), Stable Factor, Proconvertin
VIII	Antihemophilic Factor (AHG or AHF)
IX	Plasma Thromboplastic Component (PTC), Christmas Factor
X	Stuart-Prower Factor
XI	Plasma Thromboplastin Antecedent (PTA)
XII	Hageman Factor
XIII	Fibrin Stabilizing Factor (FSF)
V.W.	von Willebrand's Factor
	Fletcher Factor

TABLE II
Plasma Coagulation Factor Deficiencies

	Inheritance Pattern	Incidence per M
Afibrinogenemia (Dys--)	Autosomal Recessive	1
Hyoprothrombinemia	Autosomal Recessive	1
Factor V Deficiency	Autosomal Recessive	1
Factor VII Deficiency	Autosomal Recessive	1
Hemophilia—Classic	X-Linked Recessive	140
Hemophilia B	X-Linked Recessive	40
Factor XI Deficiency*	Dominant with Variable Penetrance	4
Factor XII Deficiency*	? Dominant with Variable Penetrance	4
Factor XIII Deficiency	Autosomal Recessive	1
von Willebrand's Disease	Dominant with Variable Penetrance	12
Fletcher Factor Deficiency	? Autosomal Recessive	1

* Bleeding tendency may be mild or absent

usual dosage given two or three times a day is calculated to raise the level of factor activity to 30 to 50 percent, in units, of the plasma volume. The latter is calculated as the weight in kg x 48 or in lbs. x 22. Table III lists the average units per bottle or bag and volume after dissolving of the currently available VIII and IX concentrates. It may be noted that most of the fractions are more than 10-fold concentrations of the amount of factor in the original plasma.

Cryoprecipitate is prepared in most blood banks. Other commercial fractions may become available soon. Any blood product may contain hepatitis virus. This is particularly true of the lyophilized fractions which have been prepared from large pools of plasma.

Replacement therapy is effective in controlling hemorrhage in about 90 percent of severe hemophiliacs. The remaining 10 percent have neutralizing antibodies which prevent the obtainment of satisfactory levels. This subject will be discussed in detail in a later paper in this series.

Pennsylvania is one of the first states to recognize the very special problems involved in the diagnosis and treatment of hemophilia and to adopt a state-supported comprehensive care program for Pennsylvania residents. This program was the result of Act 59A, signed by Governor Shapp on December 4, 1972, and implemented by the Department of Health, with the assistance of an advisory committee of physicians, patients, parents of patients, and representatives of affiliates of the National Hemophilia Foundation, on March 8, 1973. The program presently consists of special centers which offer comprehensive evaluation and re-evaluation services and blood products for hospital, outpatient, or home use. Patients must be registered on the program to receive these benefits, and insurance and Title XIX benefits are used before state program funds are expended.

Any physician may refer a patient from Pennsylvania who has hemophilia or is suspected of having hemophilia to the closest center (see list below). Diagnostic services are offered at all centers. Immediate treatment, advice, and suggestions for future treatment are also available. The centers make arrangements for the referring physician to receive clinical reports and, when feasible, to participate in the routine management of the patient. The coordinator at the center may be contacted for appointments, reports, or further information.

TABLE III
Available VIII and IX Concentrates

VIII - AHF	Units/bottle or bag	Vol. (ml) of diluent
1. Cryoprecipitate	100 to 140	±33
2. AHF (Abbott Laboratories)	±250	25
3. Hemofil (Hyland Div. Travenol Laboratories, Inc.)	±250 or ±750	10 or 30
4. Humafac (Parke-Davis & Company)	±250	6
5. Factorate (Armour Pharmaceutical Co.)	±300	25
IX - PTC		
1. Konyne (Cutter Laboratories, Inc.)	±500	20
2. Proplex (Hyland Div. Travenol Laboratories, Inc.)	±500	30

Allentown

Hemophilia Treatment Center
The Allentown Hospital Association
17th and Chew St.
Allentown, Pennsylvania 18102
Director: Dr. David Prager
Coordinator: Ms. Marion Royer
Telephone: (215) 821-2398

Darby

Hemophilia Center
Mercy Catholic Medical Center
Fitzgerald Mercy Division
Lansdowne Ave. and Bailey Rd.
Darby, Pennsylvania 19023
Director: Dr. Isaac Djerassi
Telephone: (215) 586-5020 Ext. 2210

Hershey

Harrisburg-Hershey Hemophilia Center
Milton S. Hershey Medical Center
Hershey 17033
Director: Dr. Elaine Eyster
Coordinator: Ms. Judy Haverstick
Telephone: (717) 534-8399

Lancaster

Hemophilia Center
St. Joseph's Hospital
Lancaster 17604
Director: Dr. Carroll M. Carroll
Coordinator: Ms. G. Kenneth Smithson
Telephone: (717) 397-2821 Ext. 570

Philadelphia

Hemophilia Project
Einstein Medical Center
York and Tabor Rds.
Philadelphia 19141
Director: Dr. Mehdi K. Kajani
Coordinator: Ms. Betty Griffin
Telephone: (215) 329-0700 Ext. 255

Philadelphia

Hemophilia Center
Children's Hospital of Philadelphia
1 Children's Center
34th St. and Civic Center Blvd.
Philadelphia 19104
Director: Dr. Frances Gill
Coordinator: Ms. Regina Blumenstein
Telephone: (215) 387-6000, Ext. 597

Philadelphia

Cardeza Foundation
Hemophilia Center
Jefferson Medical College
Thomas Jefferson University Hospital
1015 Sansom St.
Philadelphia 19107
Director: Dr. Sandor S. Shapiro
Coordinator: Ms. Barbara Erlick
Telephone: (215) 829-7786

Pittsburgh

The Hemophilia Center of Western Pennsylvania
Central Blood Bank of Pittsburgh
812 Fifth Ave.
Pittsburgh 15219
Director: Dr. Jessica H. Lewis
Coordinator: Miss Toni Gorenc
Telephone: (412) 391-8290 Ext. 75 or 76

Reading

Hemophilia Center
Reading Hospital
Reading 19602
Director: Dr. Charles Lusch
Coordinator: Ms. Vicky Hoover
Telephone: (215) 378-6000

Dr. Lewis is director of the Hemophilia Center of Western Pennsylvania and chairman of the Advisory Committee for Hemophilia of the Pennsylvania Department of Health. Dr. Gens is director of the Hemophilia Program of the Pennsylvania Department of Health.

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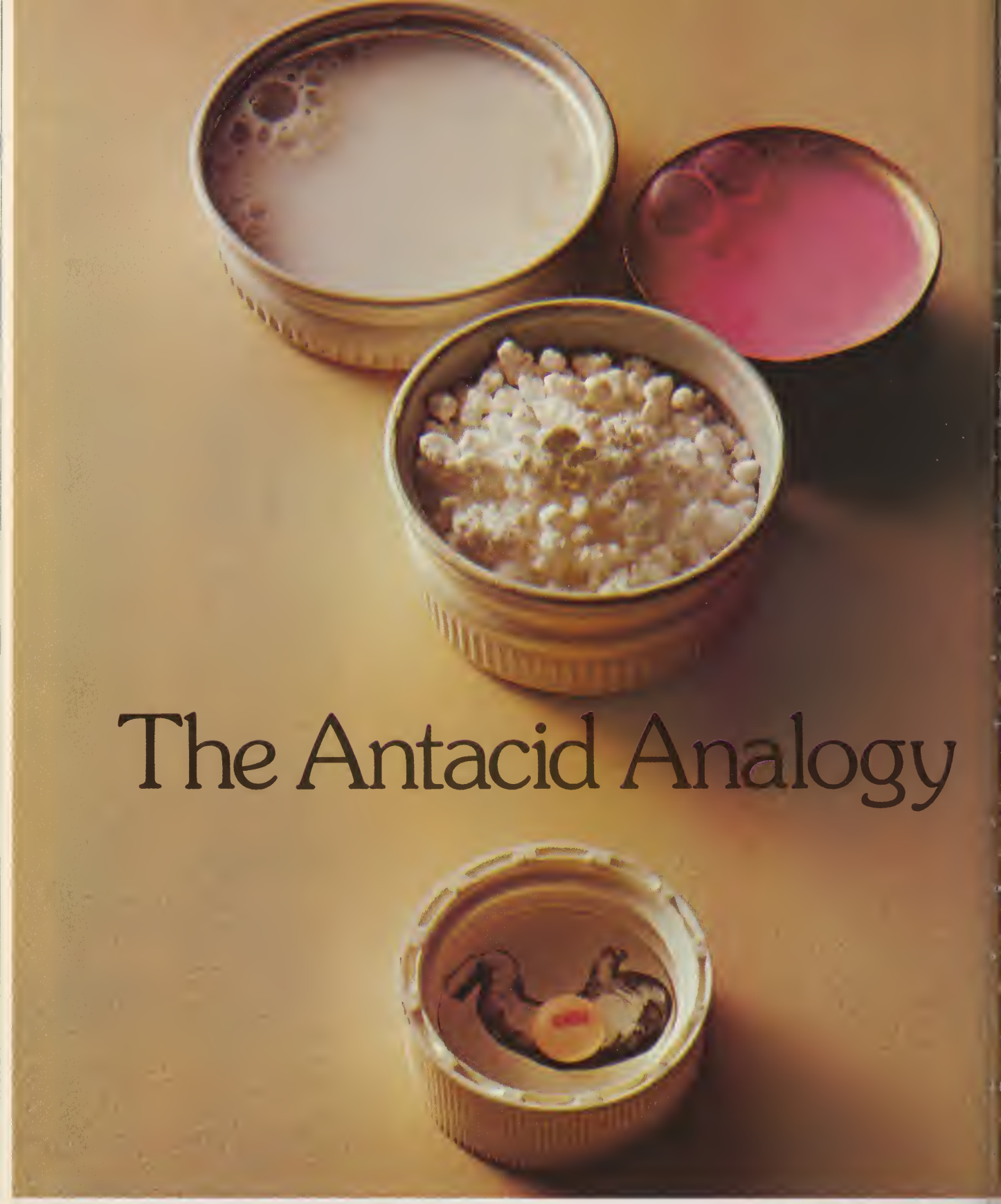

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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Opinion & Dialogue

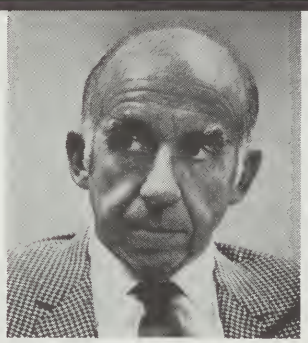
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihod on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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P·M·A

Treatment of facial fractures

ARTHUR M. CALABRETTA
WILLIAM P. GRAHAM III, M.D.
STEPHEN H. MILLER, M.D.
Hershey

Figure 1. Comminuted unstable nasal fracture treated by transnasal fixation of aluminum compression plates and the insertion of silastic nasal splints.

With today's high speed trauma, facial injuries and fractures comprise a large proportion of acute emergency room admissions. Although many may be treated without the necessity of hospitalization, certain of these injuries are among the most complicated fractures treated.

Nasal Fractures

The simple depressed or angulated nasal fracture may be best diagnosed by physical examination rather than x-ray. Occasionally, prior to the onset of edema, the fracture may be expeditiously and painlessly reduced through simple elevation of the bridge, outward displacement, and then repositioning of the depressed nasal bones. Most often local anesthesia with lidocaine containing epinephrine and topical cocaine is needed. Remolding can then be done and the septum checked for any displacement prior to the application of an aluminum splint and a small amount of intranasal lubricated gauze packing. This gauze is usually removed within twenty-four hours and the splint removed at seven days. The patient must be cautioned about the possibility of late nasal hemorrhage and the likelihood of later septal deviation and dorsal hump formation despite proper adequate initial treatment. Such changes follow upon variation in individual healing.

Comminuted nasal fractures and open nasal fractures may be unstable after reduction. The use of carved intranasal splints of silastic and small external aluminum compression plates insure the best chance of maintaining a decent nasal profile with a narrow nose and adequate airway (Figure 1). The aluminum

This paper was prepared by the division of plastic surgery, department of surgery, at the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. Dr. Graham is chief of plastic and reconstructive surgery and Dr. Miller is associate professor of surgery. Mr. Calabretta is a senior medical student. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

Figure 2. Technique of zygomatic arch elevation by using a towel clip or other heavy hook.

plates which are held by through-and-through transnasal wiring are removed at ten to sixteen days. At the same time, the splints are removed. The use of the soft silastic forms avoids prolonged nasal packing and its attendant risk of infection.

Septal injuries may be deceptive, and incomplete cracks within the cartilage are likely to produce later deformity. Submucosal hematomas must be evacuated to avoid excessive scarring and later deviation. In rare instances, a submucosal septal resection is indicated acutely.

Zygomatic Arch Fractures

These injuries result from sharp direct blows to the zygomatic arch which do not produce a classical tripod fracture, but a depressed fracture of the arch alone. Trismus is a common finding related as much to swelling and possible pressure on the temporalis muscle and tendon as impingement on the coronoid process.

Elevation with a towel clip after the infiltration with local anesthesia is very easily done[1] (Figure 2). Rare comminuted fracture may be unstable and require internal fixation.

Malar Complex Fractures

These injuries that follow blunt trauma to the cheek are typified by infraorbital anesthesia, periorbital ecchymosis, and subconjunctival hemorrhage, with or without diplopia. There is usually tenderness at the frontal zygomatic suture line and on the medial inferior orbital rim, as well as across the antral wall. Elevation of the depressed fractures is usually easily accomplished by the technique popularized by Herceg and Harding.[2] The superior orbital fracture is exposed and stabilized with a wire suture which is not tightened until the malar complex is elevated by a heavy hemostat beneath the arch and prominence (Figures 3A and B, 4A and 4B). Occasionally an unusual injury produces comminution of the malar bone and extensive internal fixation is required.

Orbital Floor Fractures

An orbital floor fracture is not a "blow out" fracture

Figures 3A and 3B. Repositioning of malar fracture by internal fixation at frontal zygomatic suture line and elevation of the prominence by a hemostat inserted through the cheek.

unless the fractures do not extend into the adjacent bones and diplopia is present. Thus, properly, a "blow out" fracture is a clinical entity substantiated by X-ray.

Originally orbital floor fractures were treated by a Caldwell Luc approach through the canine fossa with blind elevation and packing.[3] This was supplanted by the direct approach to the orbital floor through the lower lid. More recently, Tessier and others have shown that a transconjunctival approach to the orbital floor gives superb exposure and enables the surgeon to insert a prosthetic support if it is indicated.[4] This approach can be combined with the treatment of other fractures if orbital floor fractures are present.

LeFort Fractures

In 1901, based on experimental observations, LeFort defined three sites of facial weakness which could give rise to a typical injury within the midface. These are: the LeFort I, a simple transverse fracture of the maxilla; the LeFort II, a pyramidal fracture extending into the nasal aperture; and the LeFort III or craniofacial separation.

LEFORT I. Most commonly today, this results from striking one's anterior maxilla on a steering wheel or other hard ridged object. Fixation will require intermaxillary fixation with suspension of the mandible or maxilla from the zygomatic arches or orbital rims. Healing is usually rapid, and the fixation can be removed in five to six weeks.

LEFORT II. The pyramidal fracture is most readily

Figure 4B. Fracture reduced by the simple technique described in the text.

Figure 4A. Left malar fracture. Arrow indicates the opacified antrum.

Figure 5A. LeFort III fracture.

Figure 5B. LeFort III fracture reduced and fixed internally with suspension wires to the mandibular arch bar. The comminuted nasal fracture has been treated with compression plates and intranasal silastic splints.

Figure 6A. LeFort III fracture in an edentulous patient whose dentures were employed in the fixation.

Figure 6B. Usual fixation of LeFort III fracture with facial suspension wires connected to pull out wires near the temples.

treated by intermaxillary fixation with the mandible then suspended to the orbital rims, securing good anterior positioning of the maxilla. Again, fixation is needed for five to six weeks.

LEFORT III. The most severe injury in this group is the craniofacial separation, often accompanied by a mandibular fracture and intracranial injuries. Cerebrospinal fluid leaks occur most often with this fracture. If, in addition to the craniofacial separation, a vertical fracture through the central face has occurred, then transfacial fixation with a Kirschner wire between the two malar prominences may be needed. Usually the superior lateral-orbital fractures are reduced and suspension wires placed. The mandible and maxilla are placed in occlusion and intermaxillary wiring done. If the middle third of the face retrudes or the fractures are unstable, external traction may be needed. This can be a simple plaster headcap with outriggers or a sophisticated halo designed expressly for this purpose. Medial or inferior orbital fixation may also be required. Immobilization for six weeks is needed. See figures 5A and B and 6A and B.

Mandibular Fractures

Mandibular fractures occur anywhere within the mandible: symphysis, body, ramus, or subchondral. The simple undisplaced stable fracture can often be treated with intermaxillary fixation by the use of wire ligatures or the application of arch bars. The skillful surgeon can perform this task using local anesthesia without discomfort to the patient. Generally four weeks immobilization will prove sufficient.

Fractures at more than one site usually require open reduction and internal fixation of at least one of the fractures. The aim is to convert the mandible which has more than one fracture into that which has only a single unfixed fracture by the internal stabilization of the extra fractures. Subsequently, intermaxillary fixation will maintain the needed immobilization for six weeks (Fig. 7 A and B).

Dental caries and poor oral hygiene markedly

Figure 7A. Unstable fracture of the body of the mandible.

Figure 7B. Treatment of mandibular fracture with internal fixation and arch bars.

Figure 8. Segmental fracture of superior orbital rim treated by elevation and internal fixation.

increase the risk of infection as most mandibular fractures are open through the mucosa or a tooth socket. Antibiotic coverage for seven to ten days post-injury is recommended for most facial fractures. Seldom do infections occur in fractures of bones other than the mandible. Once osteomyelitis of the mandible is present, the patient is committed to a long course of immobilization, sequestrectomy, bone grafting (usually rib), and in many cases, limitation of mandibular excursion following treatment.

New techniques employing compression plates have aided in the management of complicated mandibular fractures. Immobilization is the key to good mandibular healing. In the edentulous patient, acrylic prosthetic splints may be employed to achieve proper occlusion. Circumferential wire fixation of the patient's own dentures is the best aid to immobilization and good alignment.

Often facial fractures will not "follow the book" but challenge the ingenuity of the surgeon in treating them (Figure 8). □

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Comments on PSRO and peer review

LOUIS GOODMAN, M.D.
South Side Hospital
Pittsburgh

Utilization Review Committee

According to Dr. Francis Moore, distinguished surgeon at the Peter Bent Brigham Hospital in Boston, the PSRO as a peer review mechanism is doomed to failure.* This prediction is based on his belief that the peers doing the peer reviews will constitute themselves a new nobility, a "Peerage" so to speak, who will assume the role of super peers. He predicts the demise of PSRO by 1980.

He also makes the statement that the entire thrust of PSRO will be directed to cost containment and will accomplish merely the definition of allowable or permissible charges without consideration of the quality of clinical care.

To illustrate what might be in store for the hapless conscientious physician, who (adhering strictly to the arbitrary rules of PSRO) discharges a patient prematurely at the insistence of the chairman of the PSRO committee, Dr. Moore cites a hypothetical case. The patient is depicted as a 45-year-old woman who undergoes a hysterectomy for uterine bleeding due to a small submucous fibroid. Preoperative procedures are properly done in accordance with PSRO guidelines. The postoperative course is uneventful, but on the day of prescribed discharge, the patient is weak and wobbly, and the surgeon is reluctant to discharge her. Nevertheless, because of fear of being penalized and because of insistence by the chairman of the PSRO committee, the patient is discharged. Two days later, while walking up the stairs, she suffers a fatal heart attack. The scenario is completed with two malpractice suits—one against the surgeon and the other against the chairman of the PSRO committee.

From this example Dr. Moore concludes that the definition of length of stay, permissible charges, and norms for patient care (instituted by a self-appointed peerage) may constitute peer review; they do not constitute either the practice of medicine or the definition of "high quality care."

Comment

With Regard to the Definitions of Peer and Peer Review: The basic concept of PSRO should rest on the definition of "peer" as one of the same rank—an equal, and preferably one of similar background, training, and experience. In carrying out their reviews, the specialized reviewers utilize each others' expertise in rounding out their decisions.

With Regard to the Assumption that PSRO's Entire Thrust is Cost Containment: True peer review makes this a virtual impossibility. Anyone who has served on utilization review committees knows that the crucial question of medical necessity for hospitalization and length of stay ultimately and generally, with exceptions beyond the control of the utilization committee, determines the committee's final decision. Furthermore, that decision has only to do with termination of benefits and not with discharge of the patient.

When there is a conflict between the cost containment factor and bona fide medical necessity for continued hospitalization, the latter consideration prevails. Adequate and accurate documentation recorded in the progress notes provides a strong and defensible deterrent to premature discharge of patients based soley on cost factors.

With Regard to Dr. Moore's Prediction: If the peer review committees function the way Dr. Moore predicts, then his prediction will be fulfilled. Only it will take place much sooner than 1980. If this is allowed to happen, then "It would leave a vacuum . . . . . which will be filled in a manner not to our liking, by those not of our choosing, by techniques not of our selection. And we will be powerless to protest, because we stood above the battle as it swirled about us and ultimately brought us down."** Therefore it cannot be allowed to happen. Peer review by peer groups must be the conceptual cornerstone of PSRO.

With Regard to the Alternative Proposed by Dr. Moore: If the peer review process of the PSRO brings together a group of "comrades, reviewing records and clinical procedures out of mutual interest and concern for the welfare of the patient, as equals, this new legislation will survive and might even go down in history as a triumph for self-regulation in a voluntary medical care delivery system."

This is what we propose as our objective. Intelligent self interest dictates that every effort be made to operate the peer review mechanism on a purely professional and non-bureaucratic level.

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* *Peer review and all that. Editorial, Arch. Surg. 108-397, April 1974.*

** *The PSRO issue. Editorial, JAMA. 227:1170, March 11, 1974.*

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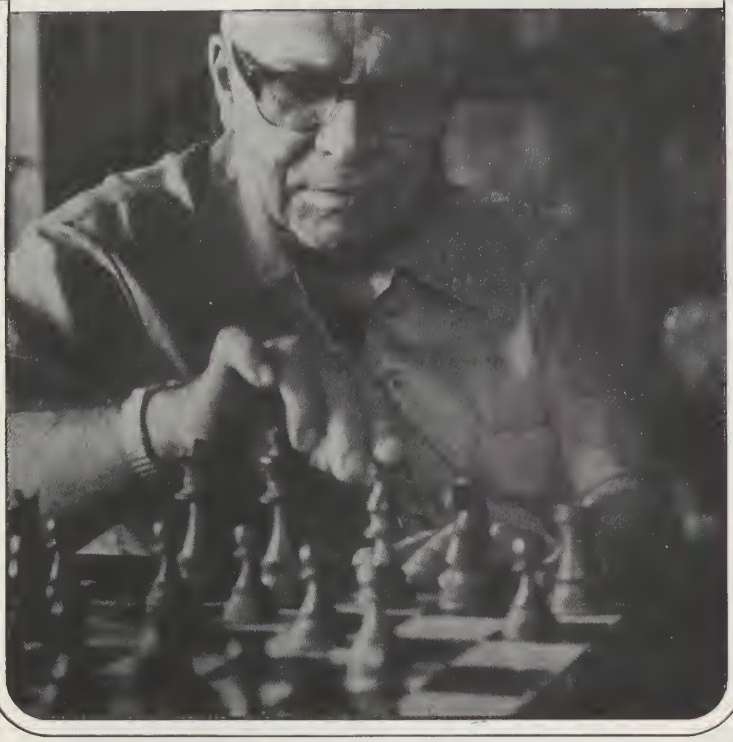

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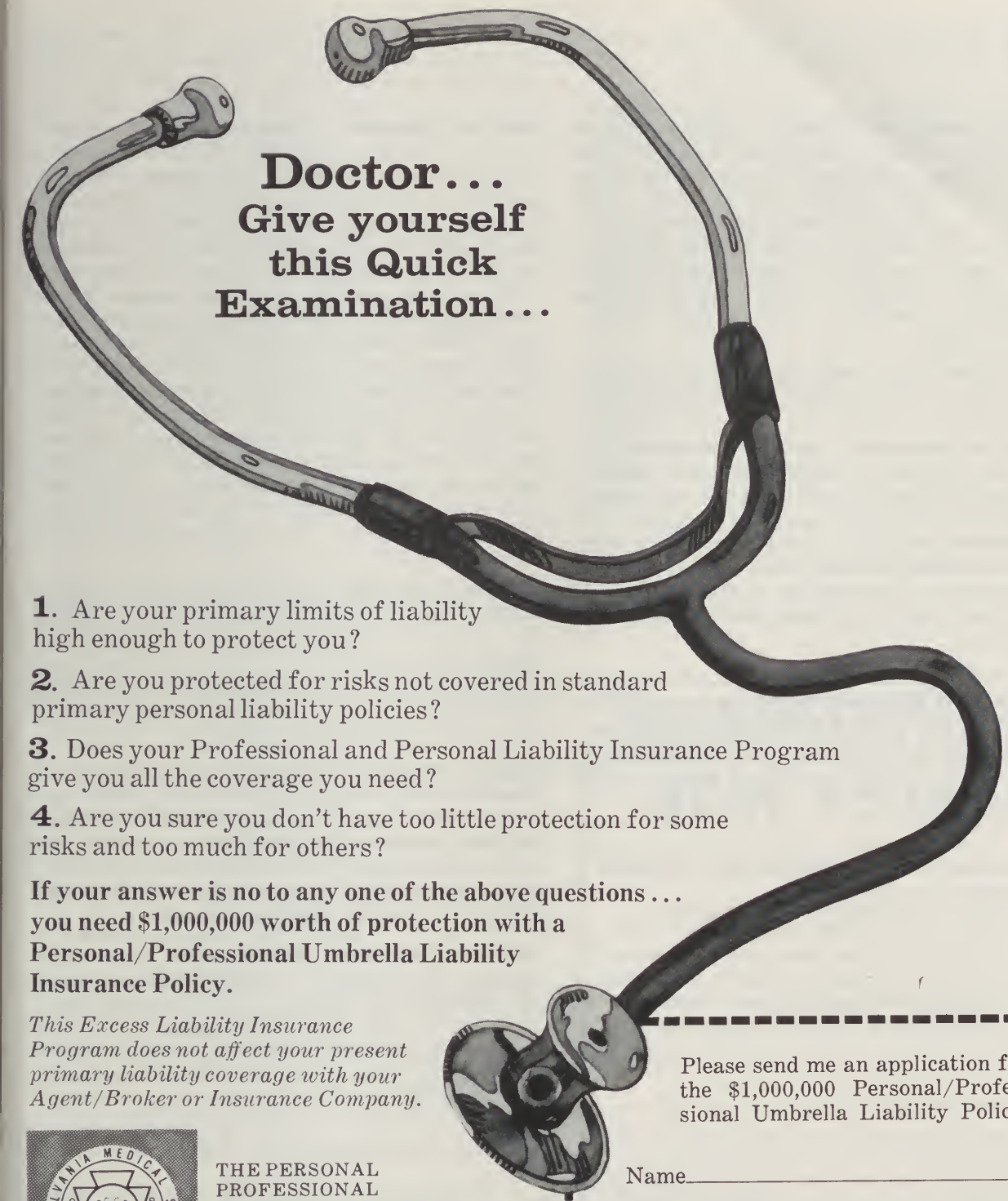

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Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

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Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

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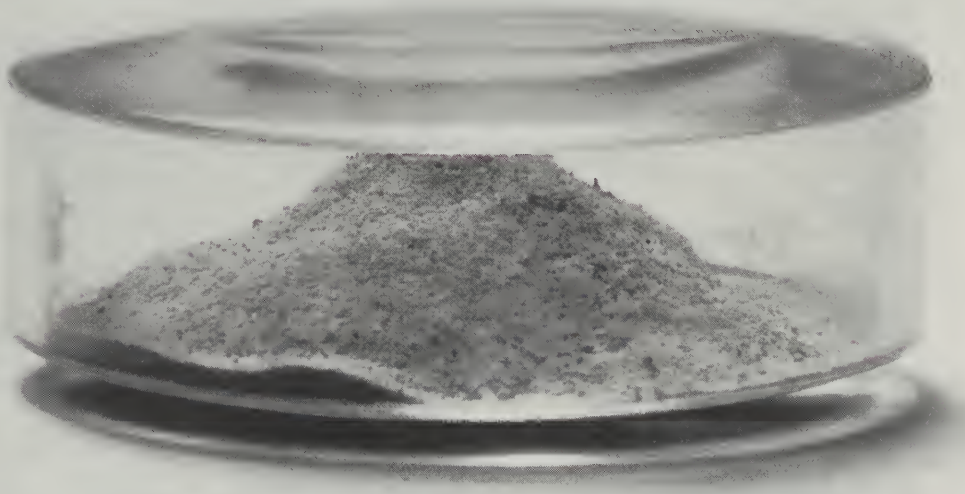

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(thyroglobulin)

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **George W. Chernoff,** North Miami Beach, Florida; Temple University School of Medicine, 1933; age 65; died November 1973. He is survived by his wife and a daughter.

• **Michael E. Farah**, Pompano Beach, Florida; Loyola University School of Medicine, Chicago, Ill., 1918; age 82; died June 8, 1974. He was a member of the American Urological Association. He is survived by his wife, a daughter and a sister.

Charles D. Haughey, Philadelphia; Yale University Medical School, 1955; age 51; died June 3, 1974. He is survived by his mother and two brothers.

• **Clare C. Kenny**, Matamoras; Loyola University School of Medicine, Chicago, Ill., 1934; age 66; died January 2, 1974. He was certified by the American Board of Abdominal Surgery and the International College of Surgeons. He is survived by his wife. Information on other survivors is not available.

• **J. Stauffer Lehman**, Ocean City, N.J.; Hahnemann Medical College and Hospital, 1931; age 68; died June 11, 1974. He was former chairman of radiology at Hahnemann Hospital, Philadelphia. Dr. Lehman was the inventor of the Lehman injector for coronary heart disease. He was certified by the American Board of Radiology and was a member of the World Health Association and the American Institute of Ultrasound in Medicine. He is survived by his wife, two sons, a sister, and a brother.

• **Joseph A. Mancuso**, Meadville; University of Buffalo School of Medicine, 1933; age 70; died June 14, 1974. He was a member of the American Society of Abdominal Surgery. Information regarding survivors is unavailable.

• **Israel Myers**, Cumberland, R.I.; University of Pennsylvania School of Medicine, 1907; age 90; died May 21, 1974. He had practiced medicine for sixty-four years. He was a diplomate of the American Board of Otolaryngology and had served on the staffs of St. Luke's and Children's Medical Center and Albert Einstein Medical Center. He is survived by his wife, a son, and a daughter.

• **Patrick E. Pellecchia**, Philadelphia; Temple University School of Medicine, 1953; age 52; died May 29, 1974. He was associate professor of community medicine at Temple University School of Medicine and chief of the section of general practice at Northeastern Hospital. He is survived by his wife; four sons, one of whom is Patrick E. Pellecchia, M.D.; two daughters; two sisters; and three brothers.

• **Alfred J. Porter,** Greensburg; University of Colorado School of Medicine, 1923; age 79; died June 13, 1974. He had practiced medicine in Greensburg for fifty years. He was medical director of Westmoreland Manor for thirty-five years until his retirement in 1971. He is survived by his wife.

• **George H. Smith,** Pittsburgh; University of Pittsburgh School of Medicine, 1928; age 70; died June 27, 1974. He is survived by his wife and his father.

• **Robert L. Shaffer**, Brookville; University of Pittsburgh Medical School, 1930; age 77; died May 29, 1974. He was a member of the American Board of Abdominal Surgeons. He is survived by his wife, two sons, a daughter, and a brother.

• **Esther F. Teplitz**, Pittsburgh; University of Pittsburgh School of Medicine, 1930; age 81; died June 15, 1974. No further information is available.

• **Henry F. Ulrich**, Sunbury; University of Pennsylvania School of Medicine, 1928; age 72; died June 9, 1974. He was a member of the Pennsylvania State Coroners Association, the American College of Surgeons, and the American Society of Abdominal Surgeons. His wife, a daughter, a sister, and a brother survive him.

John G. Ord, King of Prussia; Temple University School of Medicine, 1937; age 63; died May 11, 1974. He is survived by his wife, a stepson, two sisters, and a brother.

George D. Gammon, Andalusia; University of Pennsylvania School of Medicine, 1927; age 73; died May 8, 1974. He was former head of the department of neurology at the University of Pennsylvania School fo Medicine and a past president of the Philadelphia Neurological Society. He is survived by a daughter and two sons.

Emanuel M. Gruess, Philadelphia; University of Pennsylvania School of Medicine, 1935; age 63; died February 28, 1974. No further information is available.

Marjorie E. Gugger, Colwyn; Medical College of Pennsylvania, 1951; age 52; died February 7, 1974. No further information is available.

Bertram Poludniak, Philadelphia; Hahnemann Medical College, 1944; age 54; died February 10, 1974. No further information is available.

Nina M. Price, East Stroudsburg; Woman's Medical College (Medical College of Pennsylvania), 1907; age 91; died June 4, 1974. She is survived by seven daughters.

Evan W. Thomas, Philadelphia; New York University College of Medicine, 1933; age 83; died May 19, 1974. He was chief of the venereal disease department for New York State until 1965, when he came to Philadelphia to volunteer as a physician to the Institute for the Achievement of Human Potential. Two sisters survive him.

William A. Weaver, Jr., Bala Cynwyd; Hahnemann Medical College, 1933; age 64; died June 16, 1974. He was president of the American Institute of Homeopathy, a fellow of the American Board of Homeotherapeutics, and a member of the Pennsylvania Homeopathic Society. His wife, two sons, and three daughters survive him.

Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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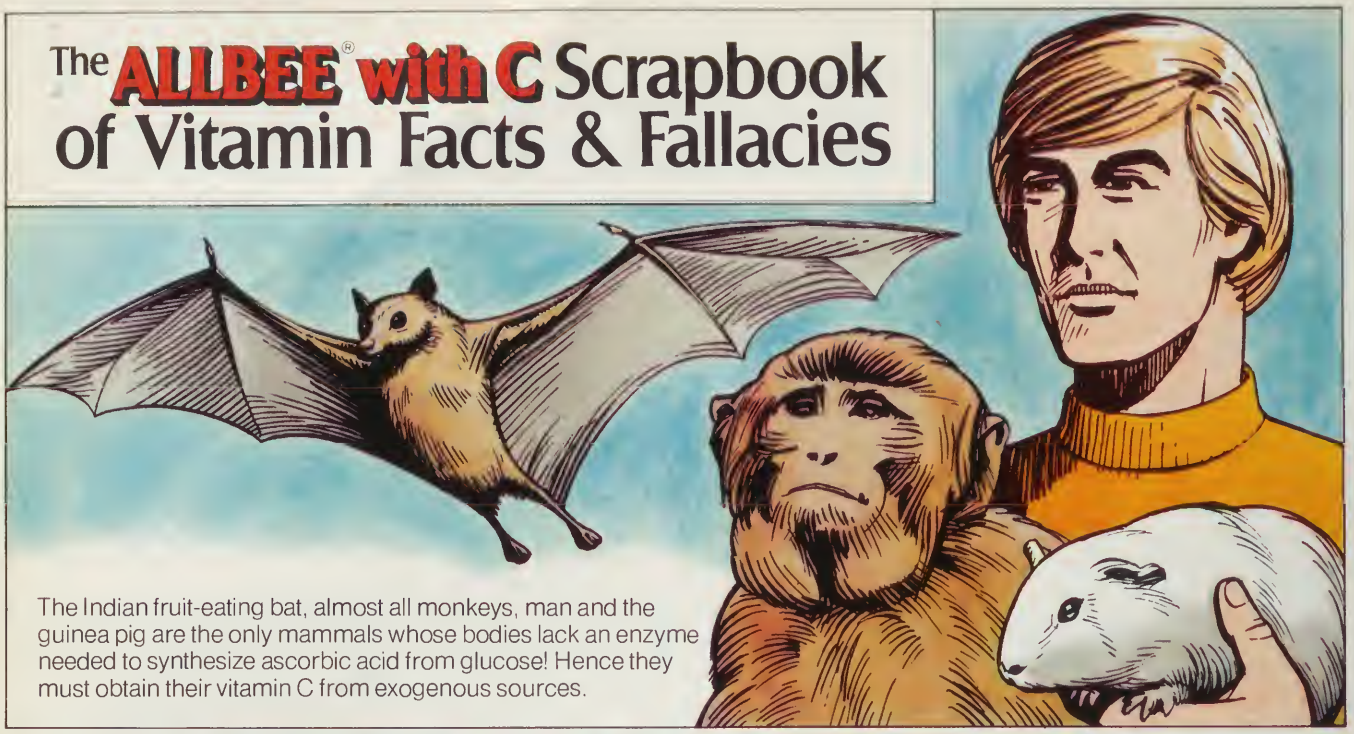
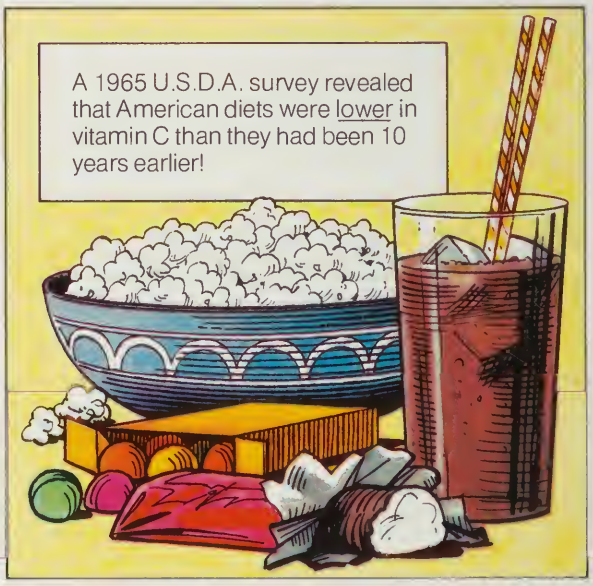
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!

The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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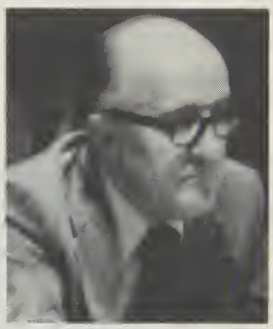
Pennsylvania Medical Society
Highlights-1974

The death of a president, the passage of the new Medical Practice Act, the funding of the Foundation by the Department of Health, Education, and Welfare, and the launching of a communications division—these are just a few of the events which made news in the Society this year.

The shape of the year began with decisions of
e 1973 House of Delegates in Philadelphia.
ıe House deliberates and directs; and the
)ciety's Board of Trustees and Councilors,
)mmittees, and four administrative councils set
)out the task of implementing the directions
d solving problems posed during deliberations
the House. Reports of each year's activity
turn in the end to their source—the House of
elegates, composed of representatives of the
)mponent county medical societies, the specialty
cieties, the Student American Medical
ssociation, and ex officio members.
William Y. Rial, M.D., from Swarthmore, a
ember of Pennsylvania's AMA delegation and
x term speaker of the PMS House, stepped
)wn to devote more time to his new job, vice
)eaker of the AMA House. Delegates elected
ce speaker, John B. Lovette, M.D., Johnstown,
s speaker; and D. Ernest Witt, M.D., Blooms-
urg, as vice speaker.



At the state dinner Ralph C. Wilde, M.D., Pittsburgh, took the oath of office as the 124th president of the Pennsylvania Medical Society. Before the end of 1973 he was hospitalized with leukemia. Dr. Wilde rallied and performed Society business. He attended a three-day legislative seminar in Lancaster, spoke at the Woman's Auxiliary Annual Spring Conference, and presided at the 1974 Officers' Conference in April. But his condition deteriorated and on July 10 at Allegheny General Hospital, he died at age 51 following complications from a splenectomy.

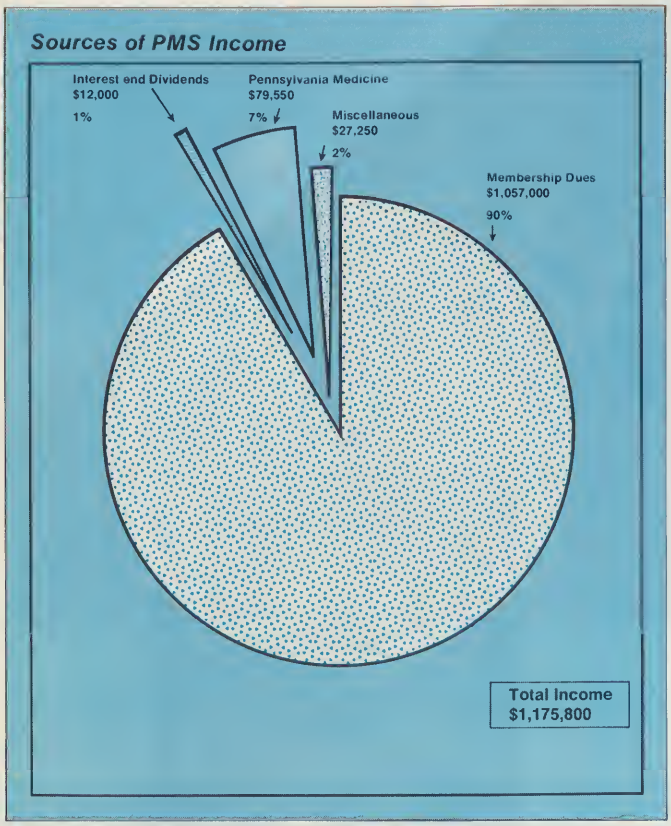
Under the constitution, the president elect, A Reynolds Crane, M.D., Philadelphia, became president. He is serving the remainder of Dr. Wilde's unexpired term and then will continue i office for the year of his presidency. David S. Masland, M.D., Carlisle, will become president elect at the Annual Session moving up from th office of vice president.

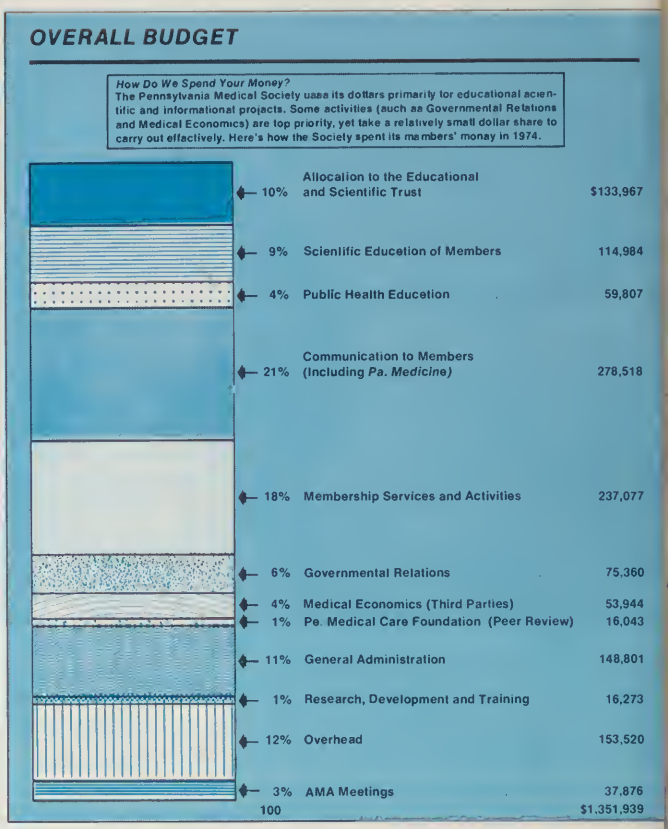
Board of Trustees and Councilors
Seated (left to right), Drs. H. Thompson Dale, A. Reynolds Crane, Cyrus B. Slease, David S. Masland, and Charles E. Schlager. Standing, Drs. John B. Lovette, D. Ernest Witt, Orlo G. McCoy, Raymond C. Grandon, William J. Kelly, Donald R. Cooper, Leroy A. Gehris, William C. Ryan, George A. Rowland, David J. Keck, Ralph K. Shields, and Kenneth L. Cooper. Dr. Robert S. Sanford was not present when the photograph was taken.

Cyrus B. Slease, M.D., Chairman, Board of Trustees and Councilors.

When the Board of Trustees reorganized after the 1973 Annual Session there were two new faces and some new hats. The Board elected Cyrus B. Slease, M.D., trustee for the Ninth Councilor District, chairman, and H. Thompson Dale, M.D., of the Sixth District, as vice chairman. Charles E. Schlager, M.D., York, newly elected secretary, joined the Board, as did D. Ernest Witt, M.D., new vice speaker. John B. Lovette, M.D., stayed on the Board in his new office of speaker of the House of Delegates, as did David S. Masland, M.D., new vice president, who had served as chairman of the Board while trustee from the Fifth District. Raymond C. Grandon, M.D., Harrisburg, former Society secretary, remained on the Board in his new position of trustee from the Fifth District.

The House-mandated communications division was launched by the Board in November with the appointment of Robert L. Lamb, former assistant secretary, as director of communications. In addition to ongoing communications activities with radio and newspapers, the new department diversified. It prepared a multimedia show for the Officers' Conference, and slide shows on PSRO and the continuing education requirement. In person communications were stepped up with additional briefings for county society executive secretaries. It also assumed publication of *Executive Report*. The communications division has served all four councils, the Board of Trustees, and the Woman's Auxiliary.





PENNSYLVANIA MEDICINE, backbone of the Society's communications program, took on a new look in 1974 as the Publication Committee, chaired by David J. Keck, M.D., Erie approved format changes. New type and revised layout make PENNSYLVANIA MEDICINE easier to read.

The State Society is a million dollar plus corporation with the 1974 budget set at $1,351,939. Accountable for this money is the Board of Trustees; recommendations on ways of spending it come from its Finance Committee. Chairman of this five-man committee is George A. Rowland, M.D., Millville. The accompanying illustrations show sources of Society income and costs of principal Society activities. 76 percent of the budget supports activities and services.

While every Board action is important to some component of the Society, some stand out for their wide impact. Such decisions included:

- Recommending that the continuing education requirement be extended to all members involved with patient care;
- Mounting a massive letter writing campaign to end Phase IV controls;
- Attacking unfair taxation of professional corporations;
- Funding and activation of the Pennsylvania Medical Care Foundation;
- Development of a position paper on health care in Pennsylvania for presentation to both political parties;
- Exchanging representatives of the Boards of the State Society and the Hospital Association of Pennsylvania.

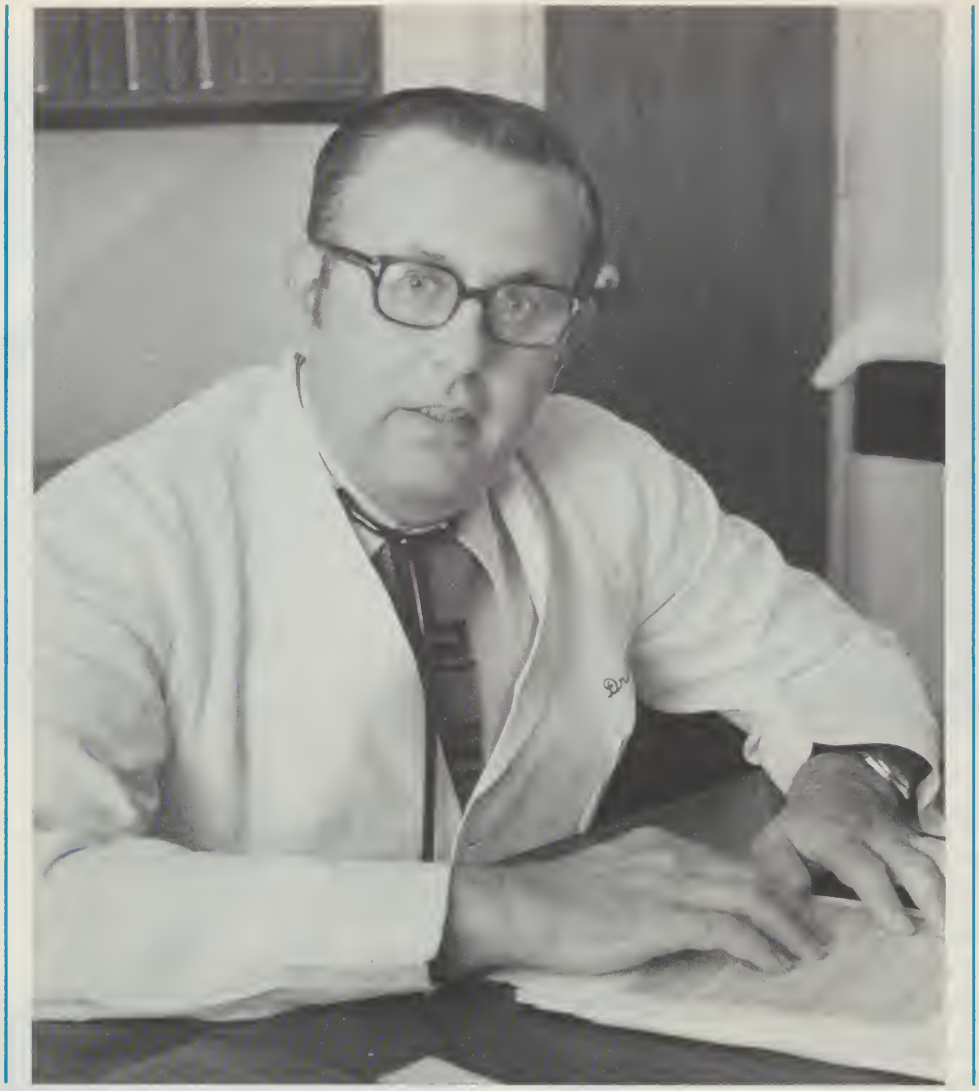
At the grass roots level, Trustees went out to meet the members. They attended county society meetings in their districts and sponsored special councilor district meetings. Some trustees helped PSRO Steering Committees become active. All trustees used time at the Officers' Conference and at Annual Session to hold councilor district meetings.

What began for John F. Rineman, executive vice president, as a visit to his family physician for an intestinal disturbance became an eight-month ordeal including three hospitalizations for surgery. Now fully recovered from complications of diverticulitis he has resumed his full schedule of Society work. Besides his administrative responsibilities for the forty-four full time employees of the Society he serves as treasurer of the Society, treasurer of the Pennsylvania Medical Care Foundation, exofficio member of the Regional Advisory Board of the Susquehanna Valley Regional Medical Program and as a member of the Advisory Committee to the executive vice president of the American Medical Association.

Although the House of Delegates' Annual Session is the focal point of the year for the Pennsylvania Medical Society, the Officers' Conference and the Scientific Assembly (renamed for 1974 the Educational Assembly) serve to disseminate information to officers and members and bring together large numbers of members for exchange of ideas.

Over 1,000 health professionals attended sessions of the 1973 Scientific Assembly, scene of special seminars on heart and lung diseases, a number of meetings planned for members of various specialty societies, and an educational conference.

A record-breaking 290 county and specialty society secretaries, executive secretaries, presidents, and presidents elect attended the 1974 Officers' Conference in April at the Host Inn, Harrisburg. John F. Rineman's multimedia report on Society activities opened the program. Panel discussions covered physician distribution and continuing education. A presentation by the Pennsylvania Medical Political Action Committee underscored election year 1974 and featured Rex E. Kenyon, M.D., member of the Board of the American Medical Political Action Committee, and Paul M. Newman, California political analyst. Mark Russell, dinner speaker, provided a fifty-minute laugh break with the fast-moving political satire for which he is famous.



John Helwig, Jr., M.D., Chairman, Council on Medical Service.

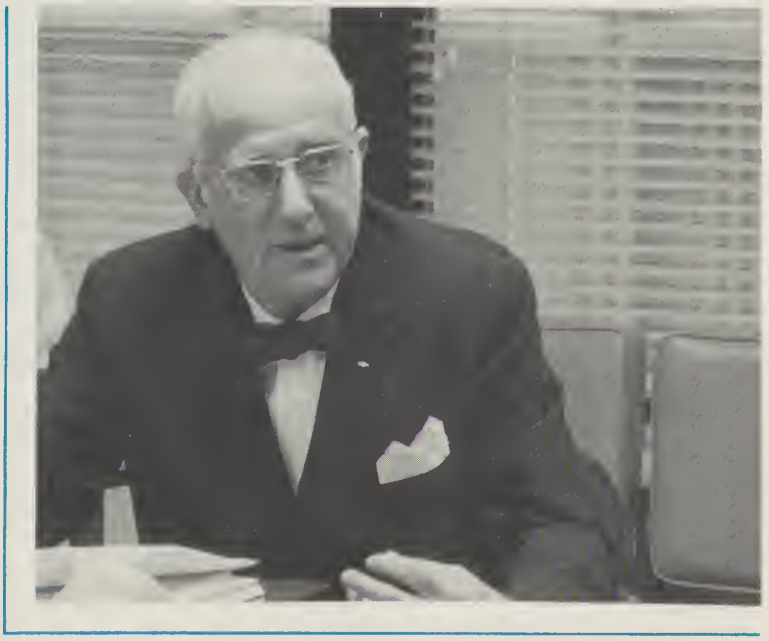
Blue Shield, under pressure from large accounts, proposed a new fee schedule plan to the 1973 House. Actuaries designed Plan C to pay "80 percent of the physician's reported charge at least 70 percent of the time." After heated debate, the House authorized continued development, provided the income limits were reviewed by the Society's Interspecialty Committee, the Board, and finally the House itself. On June 5 the Interspecialty Committee reviewed Plan C and found the income limits too high. The Blue Shield Board countered by reducing them from $7,500 per individual and $15,000 per family to $6,000 per individual and $12,000 per family. Subsequently a majority of members of the Interspecialty Committee again voted to recommend rejection (10-9) to the PMS Board.

As with many Society problems, final action o this issue is yet to come, and, as with all such complicated issues, a council or committee of th Society spends hours of study and discussion o issues to provide necessary information before decisions are made. In the Plan C matter, the Council on Medical Service provided such as pa of a diversity of activities it performs on behalf of the membership.

The council assists in the promotion and administration of fourteen Society endorsed insurance programs. Through the Commission o Professional Liability Insurance, it has provided State Society members with a program for protection in the event of a malpractice suit wit a guarantee of five years of continuous coverag and with the right to approve rate increases as they become necessary.

By 1974 the Society-sponsored three year old professional liability insurance program felt the effects of a variety of social and economic factors. The 1969 rates based on 1967 experience brought the underwriter, Argonaut Insurance Company to the Commission on Professional Liability Insurance, an arm of the Council on Medical Service. Meanwhile, the other major professional liability insurers in Pennsylvania went before the new insurance commissioner, William J. Sheppard, with rate increase filings. Review of Argonaut's figures convinced the State Society that a rate increase was justified. A. Reynolds Crane, M.D., then president elect, testified on June 18 in Philadelphia before the insurance commissioner that both the State Society and Argonaut were providing leadership in loss prevention. Out of their hands, however, are such detriments as the contingency fee system and Pennsylvania's burdensome informed consent doctrine, he said.

The specialty societies in Pennsylvania are becoming an ever stronger voice in Society affairs. At first involved only with the Council on Medical Service in its specialty advisory review committees, the specialty societies became advisors to the Board of Trustees in 1970 with the creation of the Interspecialty Committee. Three societies, the Pennsylvania Society of Anesthesiologists, Pennsylvania



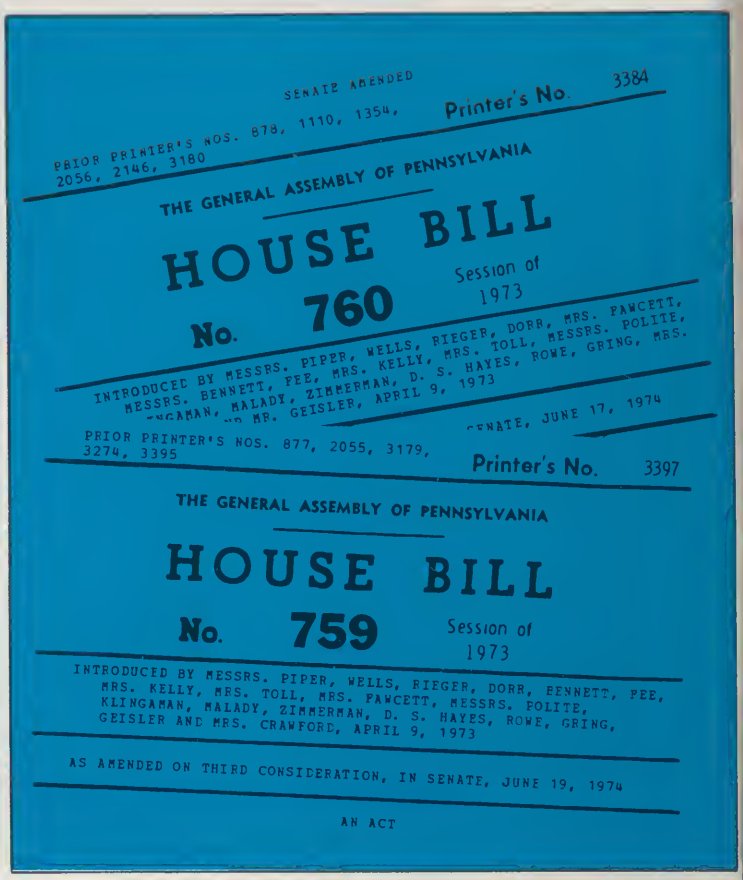
Psychiatric Society, and the Pennsylvania Radiological Society, contract with the Society for administrative services. Last year for the first time delegates from the specialty societies in Pennsylvania sat in the House of Delegates. This year they were formal attendees at Officers' Conference.

The 1974 Educational Assembly is being designed to provide specialty society business and educational sessions to the members.

The Society's first Practice Management Workshop held May 10-11 at the Hershey Motor Lodge got high marks from the 100 participants. Demand for a repeat performance led the Council on Education and Science to schedule "Principles of Medical Practice Management" in Pittsburgh, November 15-16. Earlier the Council, in cooperation with the AMA, sponsored a management workshop for senior residents preparatory to establishing their practices.

James A. Collins, Jr., M.D., Chairman, Council on Education and Science.

As the final year for the continuing education requirement (December 31, 1975) approached, the Commission on Accreditation of the Council on Education and Science stepped up its site visits. By the fall of 1974, Category One continuing education activities were available in more than 75 Pennsylvania communities. The State Society authorized 20 hospitals, one area health education center, and five state specialty societies to grant Category One Credit for their educational activities. The American Medical Association has accredited 17 Pennsylvania institutions for Category One Credit, making a total of 44 sources within the Commonwealth available to members seeking to fulfill their education requirements.



SENATE AMENDED

PRIOR PRINTER'S NOS. 878, 1110, 1354, 2056, 2146, 3180

Printer's No. 3384

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 760 Session of 1973

INTRODUCED BY MESSRS. PIPER, WELLS, RIEGER, DORR, MRS. FAWCETT, MESSRS. BENNETT, FEE, MRS. KELLY, MRS. TOLL, MESSRS. POLITE, KLINGAMAN, MALADY, ZIMMERMAN, D. S. HAYES, ROWE, GRING, MRS. [illegible] AND MR. GEISLER, APRIL 9, 1973

SENATE, JUNE 17, 1974

PRIOR PRINTER'S NOS. 877, 2055, 3179, 3274, 3395

Printer's No. 3397

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 759 Session of 1973

INTRODUCED BY MESSRS. PIPER, WELLS, RIEGER, DORR, BENNETT, FEE, MRS. KELLY, MRS. TOLL, MRS. FAWCETT, MESSRS. POLITE, KLINGAMAN, MALADY, ZIMMERMAN, D. S. HAYES, ROWE, GRING, GEISLER AND MRS. CRAWFORD, APRIL 9, 1973

AS AMENDED ON THIRD CONSIDERATION, IN SENATE, JUNE 19, 1974

AN ACT

Legislative highlight of the year was the signing into law of House Bills 759, which restructures the State Board of Medical Education and Licensure, and 760, amendments to the Medical Practice Act. Besides adding an allied health person and a public representative to the medical board, the new law strengthens the board's disciplinary powers, clarifies limited and temporary licenses, and reaffirms board authority to monitor undergraduate and post-graduate medical education in Pennsylvania.

Passage of House Bill 1729, the peer review protection measure, was another major victory for the Council on Governmental Relations. It protects physicians serving on review committees and those testifying before such committees from liability and protects the confidentiality of committee data and records.

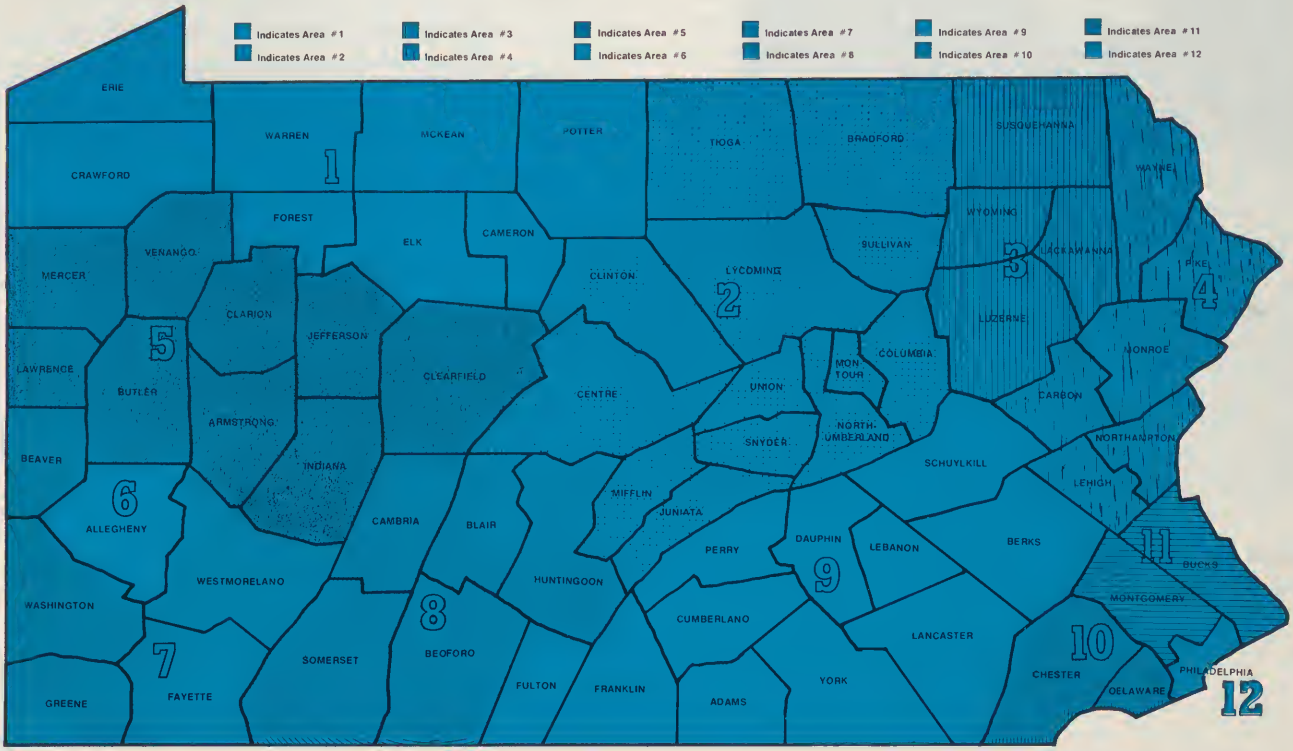
Donald E. Harrop, M.D., Chairman, Council on Governmental Relations.

The Council on Governmental Relations considered more than 100 bills during the past year as proposed health legislation proliferated on the state level. Greatest disappointment was the passage of SB 570, the amendments to the Optometric Practice Act, which the Society opposed. The new law gives optometrists with certain training the right to use drugs needed to test for glaucoma. The Society, operating on a House mandate to defeat the bill, failed.

Successful negotiations with the Department of Health removed individual physicians' office laboratories from the regulations of the new Clinical Laboratory Act. Cumbersome reporting requirements of the Drug, Device, and Cosmetic Act regulations were also deleted. Also welcomed was the Attorney General's opinion that chiropractors and optometrists are prohibited from performing acupuncture.

Robert N. Moyers, M.D., Chairman, Council on Public Service with Ulysses E. Watson, M.D., vice chairman.

A new name is on the horizon for the Council on Public Service. In June the Council recommended that the House give it a more appropriate title, "Council on Professional Relations and Services." The change reflects new activities and responsibilities, such as an intensive '75 membership recruitment campaign and plans t develop new types of member benefits. The drive to launch a cooperative for mass purchasing, which has been a major project in 1974, is an example of the latter.



The three-year old Pennsylvania Medical Care Foundation passed a milestone on April 1 with the signing of a nearly quarter million dollar contract with HEW to operate the nation's first Statewide PSRO Support Center. The contract was tacit recognition of the Society's pioneer work in peer review. The Foundation, using Society funds, had already helped determine boundaries of the twelve PSRO areas. Under the grant, major funding of the Foundation shifted to the federal government, permitting the hiring of additional staff. Technical assistance was given to areas to hold planning meetings, submit contract applications, and develop administrative procedures.

On the utilization review front, the Foundation's Certified Hospital Admissions Monitoring Program (CHAMP) was completed and sent to hospitals on July 16. Subsequently, the Department of Welfare confirmed that CHAMP and other hospital based concurrent review programs could be substituted for the Department's own Pre-Discharge Utilization Review (PDUR) program. The announcement marked the successful conclusion of two years of Foundation negotiations with the department.

The 1974 Annual Session of the House of Delegates in Pittsburgh October 10-12 will see completed the activities of the past year, and will chart a course for the future. The state dinner will highlight the session. After a four-year hiatus the Society's prized Distinguished Service Award will be awarded, this time going to the 128th President of the American Medical Association, Russell B. Roth, M.D. The Board of Trustees voted to present the award to the 60-year-old urologist from Erie because "his public life and activities are of such an outstanding nature as to reflect great credit on the profession." Past winners include Jonas Salk, M.D.; John Gibbon, Jr., M.D.; James Z. Appel, M.D.; and Eugene P. Pendergrass, M.D. The medal will be presented to Dr. Roth at the state dinner, October 11. Also to be honored at that dinner is the Woman's Auxiliary celebrating its Golden Anniversary.

Pennsylvania Guide to Continuing Medical Education

prepared by: PENNSYLVANIA MEDICAL
Continuing Education Institute
20 Erford Road Lemoyne, Pennsylvania 17043
(717) 238-1635

This list of continuing medical education announcements is published as a supplement to the September and January issues of PENNSYLVANIA MEDICINE. It includes all intermittent programs, courses, seminars, lectures, and other continuing medical education activities that were reported prior to the deadline. Items received after the deadline will be published (if presentation date has not passed) in the next supplement. For a reprint of this supplement or for submitting additional announcements, contact the Pennsylvania Medical Continuing Education Institute at the address shown above.

In most cases, each of the continuing medical education activities listed in this supplement has been granted AAFP and ACGP (osteopathic) credit. Contact those offices for details.

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PMCE Institute Board of Directors 2-S

General Abbreviations:

Acad	Academy
Admin	Administrator
Amer	American
Assn	Association
Ave(s)	Avenue(s)
Bd	Board
Blvd	Boulevard
Bldg	Building
Cntr	Center
Clin	Clinic, Clinical
Co	County
Coll	College
Comm	Committee
Cmsn	Commission
Cont	Continuing
CME	Continuing Medical Education
Dept	Department
Dir	Director
DME	Director Medical Education
Dist	District
Div	Division
Dr	Drive
E	East
Educ	Education
Exec	Executive
Gen	General
Grad	Graduate
Hosp	Hospital
Inst	Institute
Lab(s)	Laboratory, Laboratories
Med	Medical, Medicine
Mem	Memorial
Natl	National
N	North
Pkwy	Parkway
Phys	Physicians
Pa	Pennsylvania
Box	Post Office Box
Prac	Practice
Prof	Professional
Prgm	Program
RMP	Regional Medical Program
Rehab	Rehabilitation
Rd	Road
Rm	Room
Sch	School
Secy	Secretary
Serv	Service
Soc	Society
S	South
St	State, Street, Saint
Surg(s)	Surgeon(s)
Univ	University
VA	Veterans Administration
W	West

REFERENCE CODE FOR ACCREDITED PENNSYLVANIA INSTITUTIONS

(Each of the following institutions has continuing medical education accreditation to grant Category One credit.)

Note: When any of these names appear in individual announcements, the code name (rather than full name) is printed. Refer to this section for address.

ACP—Amer. Coll. of Phys., 4200 Pine St., Philadelphia 19104
ACS—Amer. Coll. of Surgs., 55 E. Erie St., Chicago, Ill. 60611
AHA—Amer. Heart Assn., Pa. Affiliate, P.O. Box 2435, Harrisburg 17105
Allegheny—Allegheny Gen. Hosp., 320 E. North Ave., Pittsburgh 15212
AMA—Amer. Med. Assn., 535 N. Dearborn St., Chicago, Ill. 60610
Chestnut Hill—Chestnut Hill Hosp., 8835 Germantown Ave., Philadelphia 19118
Clin. Path.—Pa. Assn. of Clin. Path., 1735 W. Main St., Norristown 19401
Coatesville VA—Coatesville Vet. Admin. Hosp., Coatesville 19320
Conemaugh—Conemaugh Valley Memorial Hosp., 1086 Franklin St., Johnstown 15905
Delaware Co.—Delaware Co. Mem. Hosp., Lansdowne Ave., Drexel Hill 19026
Dermatology—Pa. Acad. of Dermatology, 8220 Castor Ave., Philadelphia 19152 (c/o Charles H. Greenbaum, M.D.)
Elwyn—Elwyn Institute, 111 Elwyn Rd., Elwyn 19063
EPPI—Eastern Pa. Psychiatric Institute, Henry Ave. and Abbottsford Rd., Philadelphia 19129
Geisinger—Geisinger Med. Cntr., Danville 17821
Hahnemann—Hahnemann Med. Coll., 230 N. Broad St., Philadelphia 19102
Harrisburg—Harrisburg Hosp., Harrisburg 17101
M. S. Hershey—Pa. State Univ. Coll. of Med., M. S. Hershey Med. Cntr., Univ. Dr., Hershey 17033
Institute—Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139
Jeanes—Jeanes Hosp. of Fox Chase Center for Cancer and Med. Sciences, 7600 Central Ave., Philadelphia 19111
Jefferson—Jefferson Med. Coll. 1025 Walnut St., Philadelphia 19107
Lebanon VA—Lebanon Vet. Admin. Hosp., Lebanon 17042
Lehigh AHEC—Lehigh Valley Area Health Ed. Cntr., 335 N. Eighth St., Allentown 18102
MCP—Med. Coll. of Pa., 3300 Henry Ave., Philadelphia 19129
Mercy/Pgh.—Mercy Hosp., Pride & Locust Sts., Pittsburgh 15219
Norristown State—Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19141
Packer—Robert Packer Hosp., Sayre 18840
PAFP—Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111
Paoli—Paoli Mem. Hosp., Paoli 19301
PAO&O—Pa. Acad. of Oph. & Otol., 232 N. 5th St., Reading 19601
PMS—Pa. Med. Society, 20 Erford Rd., Lemoyne 17043
Phoenixville—Phoenixville Hosp., 140 Nutt Rd., Phoenixville 19460
Polyclinic—Harrisburg Polyclinic Hosp., Third St. and Polyclinic Ave., Harrisburg 17105
Radiology—Pa. Radiological Soc., 20 Erford Rd., Lemoyne 17043
Reading—Reading Hosp., 6th Ave. & Spruce St., Reading 19602
St. Francis—St. Francis Gen. Hosp., Penn Ave. and 45th St., Pittsburgh 15201
St. Margaret—St. Margaret Mem. Hosp., 265-46th St., Pittsburgh 15201
Temple—Temple Univ. Sch. of Med., 3400 N. Broad St., Philadelphia 19140
U. of Pa.—Univ. of Pa. Sch. of Med., 288 Med. Labs. Bldg., Philadelphia 19174
Pitt—Univ. of Pittsburgh Sch. of Med., 1022-H Scaife Hall, Pittsburgh 15261
Roentgen Ray—Phila. Roentgen Ray Soc., Temple U. Health Sciences Cntr., Philadelphia 19140
Warren State—Warren St. Hosp., Box 249, Warren 16365
Washington—Washington Hosp., 155 Wilson Ave., Washington 15301
West Penn—Western Pa. Hosp., 4800 Friendship Ave., Pittsburgh 15224
York—York Hosp., George St. & Rathton Rd., York 17405

PENNSYLVANIA MEDICAL CONTINUING EDUCATION INSTITUTE

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Dr. Frederic H. Barth
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Walter H. Burgin, M.D.
(representing: Pennsylvania Lung Association); 15 Cedar Cliff Drive, Camp Hill, Pennsylvania 17011

James A. Collins, Jr., M.D., *President*
(Chairman, Council on Education and Science, Pennsylvania Medical Society); Geisinger Medical Center, Danville, Pennsylvania 17821

Chad P. Combs
(representing: Susquehanna Valley Regional Medical Program; Susquehanna Valley Regional Medical Program, 1104 Fernwood Avenue, Camp Hill, Pennsylvania 17011

William M. Cooper, M.D., *Treasurer*
(representing: Dean, University of Pittsburgh School of Medicine); Director, Division of Continuing Education, University of Pittsburgh School of Medicine, 1022-H Scaife Hall, Pittsburgh, Pennsylvania 15261

Roger A. Cutt, Ph.D.
(representing: Pennsylvania Department of Public Welfare); Assistant Deputy Secretary for Medical Programs, Pennsylvania Department of Public Welfare, Room 308, Health and Welfare Building, Harrisburg, Pennsylvania 17120

John H. Esbenshade, II, M.D.
(Physician Actively Involved in Community Hospital Educational Programs); Lancaster General Hospital, 555 North Duke Street, Lancaster, Pennsylvania 17604

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(representing: Dean, Medical College of Pennsylvania); Associate Dean for Continuing Education and Extramural Affairs, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, Pennsylvania 19129

Robert C. Eyerly, M.D.
(representing: American Cancer Society, Pennsylvania Division, Inc.); Geisinger Medical Center, Danville, Pennsylvania 17821

Albert J. Finestone, M.D.
(representing: Dean, Temple University School of Medicine); Assistant Dean for Continuing Education, Temple University School of Medicine, 3400 North Broad Street, Philadelphia, Pennsylvania 19140

Aaron D. Freedman, M.D., Ph.D.
(representing: Dean, University of Pennsylvania School of Medicine); Associate Dean for Continuing Education, University of Pennsylvania School of Medicine, 36th and Pine Streets, Philadelphia, Pennsylvania 19174

Mary L. Graves, M.D.
(Chairman, Committee on Education, Keystone Medical Society); Rittenhouse Medical Center, 1900 Spruce Street, Philadelphia, Pennsylvania 19102

Frederick C. Hawkins, Jr., D.O.
(representing: State Board of Osteopathic Examiners); 2245 North 54th Street, Philadelphia, Pennsylvania 19131

Mrs. Mattie Humphrey
(Member of the Public Whose Daily Activities are Relative to Work of this Organization); 149 Coulter Street, Philadelphia, Pennsylvania 19144

Paul H. Keiser
(representing: The Hospital Association of Pennsylvania); York Hospital, George Street and Rathton Road, York, Pennsylvania 17405

John H. Killough, Ph.D., M.D.
(representing: Dean, Jefferson Medical College); Associate Dean, Jefferson Medical College, 1025 Walnut Street, Philadelphia, Pennsylvania 19107

Charles L. Leedham, M.D.
(representing: Pennsylvania Department of Health); Pennsylvania Department of Health, Room 832, Health and Welfare Building, Harrisburg, Pennsylvania 17120

Richard C. Lyons, M.D.
(representing: Pennsylvania State Board of Medical Education and Licensure); 4 East Second Street, Erie, Pennsylvania 16512

Frank M. Mateer, M.D., *Vice President*
(Physician Actively Involved in Community Hospital Educational Programs); West Penn Hospital, 4800 Friendship Avenue, Pittsburgh, Pennsylvania 15224

Wilbur W. Oaks, M.D.
(representing: Dean, Hahnemann Medical College); 230 North-Broad Street, Philadelphia, Pennsylvania 19102

David E. Reed, M.D.
(representing: Western Pennsylvania Regional Medical Program); Western Pennsylvania Regional Medical Program, 200 Meyran Avenue, Parkvale Savings Building, Pittsburgh, Pennsylvania 15213

Dean W. Roberts, M.D.
(representing: Greater Delaware Valley Regional Medical Program); Greater Delaware Valley Regional Medical Program, 551 West Lancaster Avenue, Haverford, Pennsylvania 19041

Benjamin Schneider, M.D.
(representing: Pennsylvania Steering Committee for Continuing Education in Psychiatry); 123 East Market Street, Danville, Pennsylvania 17821

Joseph P. Scottino, Ph.D.
(representing: Public at Large); Academic Vice President, Gannon College, Erie, Pennsylvania 16501

David A. Smith, M.D.
(representing: American Heart Association, Pennsylvania Affiliate); Polyclinic Hospital, Harrisburg, Pennsylvania 17105

Richard K. Snyder, D.O.
(Physician Actively Involved in a Community Osteopathic Hospital Educational Program); Allentown Osteopathic Hospital, 1736 Hamilton Street, Allentown, Pennsylvania 18104

Richard Swavely, Ed.D.
(representing: Pennsylvania State University Continuing Education); Assistant Director, Continuing Education, Pennsylvania State University, 501 J. Orvis Keller Building, University Park, Pennsylvania 16802

Charles M. Worrell, D.O., *Secretary*
(Physician Actively Involved in a Community Osteopathic Hospital Educational Program); Community General Osteopathic Hospital, 4300 Londonderry Road, Harrisburg, Pennsylvania 17109

Vacancy
(Member of the Public Whose Daily Activities are Relative to Work of this Organization)

ANNOUNCEMENTS

For more information, such as: frequency of sessions, fees, maximum registration, faculty, etc., contact the director at the address given in the announcement or in the REFERENCE CODE box on the cover:

Abington Mem. Hosp.; Jan. 21 - Feb. 18, 1975
(1) Newer Diagnostic Techniques - How to and When to Use; by **Temple**. (75-1-5)
Contact: W. Bernard Kinlaw, M.D., Dir. Med. Dept., Abington Mem. Hosp., 1200 York Rd., Abington 19001

Allentown Gen. Hosp.: '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; monthly, alternately at Allentown and Sacred Heart Hosp. (75-1-38)
Contact: Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa.
(2) Human Sexuality Today and Where Tomorrow?; at Holiday Inn; Sept. 19; (74-1-69)
Contact: Charles W. Reninger, Jr., M.D., Allentown Gen. Hosp., 17th & Chew Sts., Allentown 18102

Allentown; **Lehigh AHEC**; '74-'75 Academic Year
(1) Workshop on Acid Base Balance; Nov. 16; at George Washington Motor Lodge (74-1-28)
Contact: John Galgon, M.D., 1730 Chew St., Allentown 18102.

Allentown; Sacred Heart Hosp.; '74-'75 Academic Year
(1) Visiting Lectureship Program; by Allentown Phys. Anesthesia Assoc., Inc. **and U. of Pa.**; 3 times monthly, 8 months (75-1-210)
Contact: Ramon J. Deeb, M.D., Dir. of Educ., APAA, Inc., 421 Chew St., Allentown 18102

Aliquippa; Sept. 18, 1974 - May 21, 1975
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Beaver Co. and Aliquippa Hosps., Third Wednesdays (75-1-119)
Contact: Mrs. Susan Frey, Exec. Secy., Beaver Co. Med. Soc., 350 Adams St., Rochester 15074

Altoona Hospital; Oct. 1974 - June, 1975
(1) Continuing Medical Education Program; by Penn State and **Jefferson** (75-1-39)
Contact: Philip W. Hoovler, M.D., DME, Altoona Hosp., Altoona 16601

Bedford; Apr. 22-24, 1975
(1) Annual Conference - **PAO&O** (75-1-6)
Contact: Donald Kamerer, M.D., Secy., PAO&O.

Bethlehem; Nov. 13, 1974
(2) Annual Scientific Meeting—Eastern Pa. Chapt, Amer. Coll. of Surgs.; at Holiday Inn East. (74-1-22)
Contact: George W. Hartzell, Jr., M.D., Secy., 2004 Allen St., Allentown 18104

Bethlehem, St. Luke's Hosp.; '74-'75 Academic Year
(1) Important Topics in Internal Medicine; by **Lehigh AHEC** and **MCP**; monthly, Sept-June (75-1-49)
Contact: William R. Thompson, M.D., Chief, Dept. of Med., St. Luke's Hosp., 801 Ostrum St., Bethlehem 18015
(1) Important Topics in Obstetrics and Gynecology; by **Lehigh AHEC** and **MCP**; monthly Oct. - June (75-1-50)
Contact: Frank S. Flor, M.D., Chief, Dept. of Ob/Gyn, St. Luke's Hosp., 801 Ostrum St., Bethlehem 18015
(1) Important Topics in Psychiatry; by **Lehigh AHEC** and **MCP**; monthly, Oct-June (75-1-51)
Contact: Leon A. Skweir, M.D., Dept. of Psych., M.C.P.

Key to symbols:
( ) Numbers in parentheses at the beginning of an announcement indicate the PRA Category number in which attendance at this program should be reported. You may report each hour of attendance.
(75-1-XX) Numbers in parentheses at the end of an announcement are code numbers which will be helpful as a cross reference from the Subject Index section of this supplement.
Bold Face Type indicates an institution that has Category One accreditation. This name MUST APPEAR on your PRA APPLICATION to the AMA if you are to receive Category One credit.

Bridgeville; Mayview State Hosp.; June 11, 1974 - Mar. 11, 1975
(1) Continuing Education for Physicians; by **Pitt.**; second Tuesdays (75-1-110)
Contact: Robert Trivus, M.D., Superintendent, Mayview St. Hosp., Bridgeville 15017

Bristol; Sept. 3, 1974 - June 2, 1975
(1) Program of Continuing Medical Education; at Lower Bucks Hosp.; by **PAFP.** (75-1-40)
Contact: Administrator, Lower Bucks Hosp., Bath Rd. @ Route 13, Bristol 19007.

Butler; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly, Sept-June (75-1-111)
Contact: S. A. Nallathambi, M.D., Prgm. Chrm., Butler Co. Med. Soc., 230 S. Washington St., Butler 16001

Canonsburg Gen. Hosp.; Sept. 10, 1974 - May 6, 1975
(1) Continuing Education for Physicians; by **Pitt**; monthly (75-1-112)
Contact: Louis Signorella M.D., Canonsburg Gen. Hosp., Canonsburg 15317

Champion; Sept. 20-22, 1974
(1) Advances in Dermatology - 1974; by **Dermatology**; at Seven Springs (74-1-10)
Contact: Charles H. Greenbaum, M.D., Dermatology

Charleroi; Sept. 17, 1974 - Feb. 18, 1975
(1) Continuing Education for Physicians; by **Pitt**; alternately at Charleroi Div. and Monongahela Div., Monongahela Valley Hosp. (75-1-41)
Contact: U.A. DeRienzo, M.D., Charleroi Div., Monongahela Valley Hosp., Inc., Charleroi 15022

Chester; Sept. 10, 1974 - May 27, 1975.
(1) Continuing Education Program; at Crozer-Chester Med. Center; by **Hahnemann** (75-1-92)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

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Coatesville VA; Oct. 16, 1974
(1) Biological Considerations in the Treatment of Neuropsychiatric Conditions; by **Jefferson** and Chester Co. Med. Soc. (74-1-21)
Contact: J. Clifford Scott, M.D., Dir., Prof. Educ., Coatesville VA.

Danville; **Geisinger**; '74-'75 Academic Year
(1) Cardiovascular Conference; Wednesdays (75-1-95)
(1) Cardiac Electrophysiology Conference; Fridays (75-1-97)
(1) Dermatology Conference; Daily (75-1-98)
(1) Dermatology for the Non-Dermatologist; Oct. 23 (74-1-24)
(1) Clinical Aspects of Pituitary Disease; Nov. 13 (74-1-42)
(1) Common Problems in Practice; at Danville Holiday Inn; by Susquehanna Valley Inter-hospital Organization; Sept. 18 - Oct. 2 (74-1-40)
(1) Montour Co. Med. Soc. Visiting Professor Program; Third Mondays (75-1-108)
(1) Advances in Internal Medicine; Second Wednesdays (75-1-101)
(1) Advances in Medical Pharmacy and Therapeutics; Fourth Wednesdays (75-1-102)
(1) Hospital Grand Rounds; Fridays (75-1-103)
(1) Medical Clinical Pathologic Conference; First Wednesdays (75-1-100)
(1) Neurology-Neurosurgery Conference; Mondays (75-1-105)
(1) Primary Cesarean Section Review; Third Tuesdays (75-1-93)
(1) Head and Neck Tumor Conference; Mondays (75-1-106)
(1) Multidisciplinary Tumor Conference; First and Third Tuesdays (75-1-107)
(1) Converting Your Serology Lab to Microtiter: Oct. 25 (74-1-4)
(1) Pediatric Perinatal Conference; Third Thursdays (75-1-94)
(1) Pediatric Teaching Conference; Tuesdays and Thursdays (75-1-96)
(1) Pediatric Grand Rounds; Second and Fourth Tuesdays (75-1-104)
(1) Pulmonary Emergencies; Oct. 30 (74-1-41)
(1) Rehabilitation Medicine Teaching Program; Thursdays (75-1-99)
Contact: Mildred K. Fleetwood, Ph.D., Secy., Educ. Cmte., Geisinger

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DuBois; DuBois Hosp.; Winter '75
(1) Continuing Education for Physicians; by **Pitt.** and Jefferson Co. Med. Soc.; weekly (75-1-136)
Contact: W. G. Lundgren, M.D., Deposit Natl. Bank Bldg., DuBois 15801

DuBois; Maple Ave. Hosp.; Oct. 3, 1974
(1) Current Aspects of Cardiovascular Disease 1974; by **Geisinger**; at Sheraton Motor Inn. (74-1-13)
Contact: Howard Fugate, Jr., M.D., Maple Ave. Hosp., DuBois 15801.

Easton Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **Hahnemann**; Oct. 2 - June 4 (75-1-10)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

(1) Psychiatric Luncheon Conference; by **Hahnemann**; monthly, Sept. 23-June 16 (75-1-217)
Contact: Richard E. Hicks, M.D., Dept. of Mental Health Sciences, Hahnemann.

Erie; Sept. 20-21, 1974
(2) Trustee, Administrator and Physician Institute (74-1-76)
Contact: Richard L. Storrer, Hosp. Educ. and Research Foundation, Box 608, Camp Hill 17011

Franklin Hosp.; '74-'75 Academic Year
(1) Postgraduate Seminar for Physicians; by **Jefferson**; Nov. 13, 1974. (74-1-7)
Contact: Helen Griffin, M.D., Chrm., Educ. Cmte., Franklin Hosp., Franklin 16323
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Franklin, Oil City and Titusville Hosps. (75-1-113)
Contact: Robert M. Pilewski, M.D., Venango Co. Med. Soc., 9 Glenview Ave., Oil City 16301

Harrisburg; Oct. 25, 1974
(2) Central Pa. Chapter, Amer. Coll. of Surgeons; at Host Inn (74-1-90)
Contact: William P. Graham, III, M.D., M.S. Hershey

Harrisburg; Oct. 25, 1974
(2) Pa. Orthopaedic Soc. (Annual Meeting); at Host Inn (74-1-80)
Contact; John B. Blakley, M.D., Pres., P.O.S., 1 Allegheny Sq., Allegheny Center, Pittsburgh 15212.

Harrisburg; Oct. 25, 1974
(2) Pa. Acad. of Physical Medicine and Rehabilitation (Fall Meeting); at Host Inn (74-1-81)
Contact: Leon Reinstein, M.D., Secy-Treas., PAPM&R, Dept. of Rehabilitation Med., Jefferson.

Harrisburg; Oct. 25, 1974
(2) Pa. Psychiatric Society (Fall Meeting); at Host Inn (74-1-82)
Contact: Wilbert A. Lyons, M.D., Prgm. Chrm., PPS, 20 Erford Rd., Lemoyne, 17043

Harrisburg; Oct. 25, 1974
(2) Robert H. Ivy Soc. (Plastic Surgery); at Host Inn (74-1-89)
Contact: William P. Graham, III, M.D., M.S. Hershey

Harrisburg; Community Gen. Osteo. Hosp.; Oct. 3 - Nov. 19, 1974
(2) Program for Continuing Medical Education (74-1-14)
Contact: Charles M. Worrell, D.O., DME, Community Gen. Osteo. Hosp., Harrisburg 17109

Harrisburg; **PMS**; '74-'75 Academic Year
(2) An Overview of Acupuncture; Oct. 23; at Host Inn (74-1-77)
(2) Physician in Long-Term Care Facility; Oct. 24-25; at Host Inn (74-1-78)
Contact: Council on Educ. and Science, PMS.

Harrisburg; **Harrisburg**; '74-'75 Academic Year
(1) Continuing Education for Family Practitioners; monthly Sept. - Apr.; alternately at **Harrisburg** and **Polyclinic** Hosps. (75-1-124)
(1) Problems in Medicine; weekly (75-1-125)
(1) Keep Sharp in Surgery; one day alternate weeks (75-1-126)
(1) Medical Grand Rounds; Tuesdays (75-1-127)
Contact: Thomas F. Fletcher, M.D., Dir. of Med. Affairs, Harrisburg

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Haverford State Hosp.; Oct. 1-29, 1974
(1) Contemporary Trends in Psychopharmacology: A Comprehensive Review; by the **Institute** (74-1-8)
Contact: Howard B. Rosen, M.D., Dir. of Prof. Educ., Haverford St. Hosp., 3500 Darby Rd., Haverford 19041

Hazleton St. Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**, Thursdays, Sept. 19 - May 29 (75-1-47)
Contact: Aaron D. Freedman, M.D., Assoc. Dean., U. of Pa.

Hershey; **AHA**; Sept. 27-28, 1974
(1) Role of Practitioner in Treatment and Preventative Management of Cardiovascular Disease; at Hershey Motor Lodge and Convention Center (74-1-92)
Contact: AHA, Pa. Affiliate

Hershey; **M. S. Hershey**;'74-'75 Academic Year
(1) Evenings in Cardiology; 1st Wednesdays (75-1-24)
(1) Family & Community Medicine; Tuesdays (75-1-25)
(1) Emergency Medicine; Tuesdays (75-1-26)
(1) Endocrinology and Reproductive Biology; Wednesdays (75-1-37)
(1) Medical Grand Rounds; Thursdays (75-1-27)
(1) Neurology-Neurosurgery Grand Rounds; Saturdays (75-1-28)
(1) Obstetrics and Gynecology Grand Rounds; Saturdays (75-1-29)
(1) Pathology Study Group; 2nd Wednesdays (75-1-30)
(1) Pediatrics Grand Rounds; Thursdays (75-1-31)
(1) Pediatric-Pathology Conference; 2nd Fridays (75-1-32)
(1) Neonatal Teaching and Pathology Rounds; Tuesdays (75-1-33)
(1) Psychiatry Grand Rounds; 1st & 3rd Thursdays (75-1-34)
(1) Radiology Grand Rounds; 1st & 3rd Thursdays (75-1-35)
(1) Surgery Grand Rounds; Saturdays (75-1-36)
Contact: Ray A. Snyder, Area Director, Dept. of Cont. Med. Educ., M. S. Hershey

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Kittanning; Armstrong Co. Mem. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; semi-monthly (75-1-138)
Contact: Roderick R. McLeod, M.D., Box 150, Kittanning 16201.

Lancaster Gen. Hosp.; '74-'75 Academic Year
(1) Program in Continuing Medical Education; by **Temple**, weekly (75-1-52)
(1) Clinical Correlation in Family Medicine; by **Temple**; weekly (75-1-199)
(1) Human Dimensions in Medicine; by **Temple** and **Institute**; weekly (75-1-200)
(1) Ambulatory Health Care Conference; by **Temple**; weekly (75-1-201)
(1) Medical Grand Rounds; by **Temple**; weekly (75-1-202)
(1) Monthly Staff Meeting; by **Temple** (75-1-203)
Contact: John H. Esbenshade, Jr., M.D., DME, Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604

Lancaster; St. Joseph's Hosp.; '74-'75 Academic Year.
(1) Postgraduate Seminars for Physicians; by **Jefferson**; bi-monthly, Sept. 18 - May 28 (75-1-53)
Contact: Kenneth Carroll, M.D., Med. Dir., St. Joseph's Hosp., 250 College Ave., Lancaster 17604

Lock Haven Hosp.; '74-'75 Academic Year
(1) Program of Continuing Medical Education; by **Polyclinic**; second and third Wednesdays Oct., Nov., Jan., Feb., Mar. (75-1-272)
Contact: William C. Long, Jr., M.D., 53 W. Main St., Lock Haven 17745

McKeesport Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; weekly Fall of '74. (74-1-43)
Contact: Frank Bondi, M.D., McKeesport Hosp., McKeesport 15132
(1) Continuing Education for Physicians; by **Pitt.**; weekly Winter of '75. (75-1-114)
Contact: Rudolph Buck, M.D., McKeesport Hosp., McKeesport 15132

Meadowbrook; Holy Redeemer Hosp.; '74-'75 Academic Year
(1) Medical Seminars for Physicians; by **Jefferson**; Sept. 18, 1974 - May 7, 1975 (75-1-19)
Contact: W. F. Warrender, M.D., Co-Chrm. Educ. Cmte., Holy Redeemer Hosp., Meadowbrook 19046.
(1) Continuing Education Program; by **Hahnemann**; Oct. 10, 1974-Mar. 12, 1975 (75-1-11)
Contact: Robert J. Schaefer, Ex. Dir. Cont. Educ., Hahnemann

Monongahela; Sept. 17, 1974 - Jan. 21, 1975
(1) Continuing Education for Physicians; by **Pitt**; alternately at Charleroi and Monongahela Div., Monongahela Valley Hosp. (75-1-42)
Contact: H. J. Levin, M.D., Monongahela Div., Monongahela Valley Hosp., Inc., 426 W. Main St., Monongahela 15063.

New Castle; Sept. 3, 1974 - Mar. 4, 1975
(1) Continuing Education for Physicians; by **Pitt** and Lawrence Co. Med. Soc. (75-1-109)
Contact: James Bower, M.D., Chrm. Cmte on Cont. Med. Educ., Lawrence Co. Med. Soc., Temple Bldg., New Castle 16101

New Kensington; '74-'75 Academic Year
(1) Continuing Education for Physicians; at Citizens Gen. Hosp.; by **Pitt**; some Tuesdays Sept. 3 - Dec. 3 (74-1-16)
(1) Continuing Education for Physicians; at Holiday Inn; by **Pitt.** and Tri-Co. Branch Med. Soc., First Wednesdays (74-1-15)
Contact: Walter Zuck, M.D., Citizens Gen. Hosp., New Kensington 15068

Norristown State, '74-'75 Academic Year
(1) Endocrinology for Psychiatrists; weekly, Feb. 18 - Mar. 11 (75-1-207)
(1) Medical Genetics; weekly, Nov. 8 - Dec. 13 (74-1-73)
(1) Limbic System; weekly, Jan. 10-24 (75-1-209)
(1) Medical Practice and the Law; weekly, Feb. 6 - Apr. 24 (75-1-204)
(1) Problems in Neurological Management; weekly, Oct. 16 - Nov. 13 (74-1-71)
(1) Intensive Review of Neurology; weekly, Sept. 9 - Apr. 14 (75-1-206)

(1) PSRO and the Impact of Government on Medicine; weekly Sept. 6-20 (74-1-72)
(1) Partial Hospitalization Workshop; weekly, Jan 8 - Feb. 12 (75-1-208)
(1) Psychopathology for Medical Practitioners; weekly, Sept. 10 - Oct. 15 (74-1-70)
(1) Psychopharmacology Workshops; monthly, Sept. 27 - May 2 (75-1-205)
(1) Human Sexuality; Oct. 12 (74-1-74)
Contact: John D. Pruitt, M.D., Dir., Cont. Med. Educ., Norristown State

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Oil City; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Oil City, Titusville and Franklin Hosps. (75-1-113)
Contact: Robert M. Pilewski, M.D., Venango Co. Med. Soc., 9 Glenview Ave., Oil City 16301

Philadelphia; **ACP**; '74-'75 Academic Year
(1) Innovations in the Diagnosis and Management of Acute Myocardial Infarction; at **Jefferson**; Oct. 30 - Nov. 1 (74-1-2)
(1) Physiologic Approaches to the Diagnosis and Treatment of GI Disease; at Philadelphia Marriott; by **U. of Pa.**; Sept. 30 - Oct. 3 (74-1-3).
(1) Mechanisms and Management of Clinical Pulmonary Disease; at **U. of Pa.**; Sept. 30 - Oct. 4 (74-1-6)
(1) Recent Developments in Medical Oncology; at Coll. of Phys. of Philadelphia; by **Jeanes**; May 12-14 (75-1-2)
Contact: Calvin F. Kay, M.D., Deputy Exec. Vice President, ACP

Philadelphia; Albert Einstein Med. Center - Northern Div.; '74-'75 Academic Year
(1) Anesthesia Seminar; by **Temple**; 3 days a week Oct 7 - May 29 (75-1-246)
(1) Cardio-Pulmonary-Renal Research Seminars; by **Temple**; every other week July 1 - June 20 (75-1-247)
(1) Network for Cont. Educ. TV Series; by **Temple**; 4 days a week, all year (75-1-248)
(1) TV Grand Rounds in Medicine; by **Temple**; weekly, Sept 18 - July 9 (75-1-249)
(1) Renal Conference; by **Temple**; weekly, all year (75-1-250)
(1) Kidney Transplant Conference; by **Temple**; weekly, all year (75-1-251)
(1) Medical Grand Rounds; by **Temple**; weekly, Sept 10 - June 24 (75-1-252)
(1) Basic Pathophysiology in Internal Medicine; by **Temple**; weekly, Sept. 9 June 9 (75-1-253)
(1) Neurology Grand Rounds; by **Temple**; weekly, all year (75-1-267)
(1) Clinical Neurology and Neuro-ophthalmology; by **Temple**; weekly, Oct. 3 June 26 (75-1-254)
(1) Neuro-radiology Conference; by **Temple**; weekly, all year (75-1-255)
(1) Obstetrics and Gynecology Grand Rounds; by **Temple**; weekly, all year (75-1-256)
(1) Reproductive Endocrinology and Infertility; by **Temple**; every other week, Sept 3 - May 13 (75-1-257)
(1) Clinical Neuropathological Correlation Conference; by **Temple**; every other week all year (75-1-258)
(1) Autopsy Review Conference; by **Temple**; weekly, all year (75-1-259)
(1) Pediatric Grand Rounds; by **Temple**; weekly, all year (75-1-260)
(1) Nuclear Medicine - Introductory Physics and Clinical Aspects; by **Temple**; weekly, Apr. 2 - July 16 (75-1-261)
(1) Radiation Therapy - Introductory Physics and Clinical Aspects; by **Temple**; 2 days a week, Dec. 2 - Mar. 31 (75-1-262)
(1) Radiology Grand Rounds; by **Temple;** weekly, Sept. 16 - May 12 (75-1-263)
(1) Introduction to Radiological Physics and Physics of Diagnostic Radiology; by **Temple**; weekly, Aug. 5 - Nov. 27 (74-1-84)
(1) Surgical Basic Science Conference and Lecture Series; by **Temple**; weekly, Sept. 3 - May 27 (75-1-264)
(1) General Surgery Conference; by **Temple**; weekly, Sept. 7 - June 28 (75-1-265)
(1) Departmental Surgical Conference; by **Temple**; weekly, Sept. 5 - June 26 (75-1-266)
Contact: Irving Woldow, M.D., Coordinator of Med. Educ., Albert Einstein Med. Center - Northern Div., York & Tabor Rds. Philadelphia 19141

Philadelphia; **Amer. Coll. of Cardiology;** '74-'75 Academic Year
(1) Echocardiography in Its Clinical Setting; Apr. 16-18, 1975 (75-1-290)
(1) Optimal Standards of Care in Cardiac Emergencies; Apr. 22-24, 1975 (75-1-291)
(1) Core Curriculum: Mechanisms and Therapy of Cardiac Arrhythmias; Sept. 12-14 (74-1-17)
Contact: Miss Mary Anne McInerny, Dir., Dept. of Cont. Educ. Prgms., Amer. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

Philadelphia; Colon and Rectal Surgs.; Sept 12, 1974
Quarterly Scientific Meeting; Pa. Soc. of Colon and Rectal Surg.; at Union League (74-1-65)
Contact: Indru T. Khubchandani, M.D., Liberty Square Med. Center, 501 N. 17th St., Allentown 18104.

Philadelphia; **EPPI**; '74-'75 Academic Year
(1) Recent Advances in Child Psychiatry, Apr. 3 - May 8 (75-1-82)
(1) Introduction to Family Therapy: Practical Experience and Theoretical Applications; Wednesdays, Sept. 18 - Apr. 30 (75-1-83)
(1) Drug Interaction: Psychoactive Drugs in Combination with Other Commonly Prescribed Drugs; Thursdays, Jan. 1 - Feb. 20 (75-1-84)
(1) Genetics and Psychiatry; Thursdays, Oct. 3 - Nov. 14 (74-1-33)
(1) Altered States of Awareness in Psychotherapy; Feb. - Apr. (75-1-85)
Contact: Geraldine DePaula, M.D., Acting Dir. of CME, EPPI.

Philadelphia; Frankford Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; weekly, Sept. 13 - June 21; by **MCP**. (75-1-244)
Contact: Ronald E. Cohn, M.D., Med. Dir., Frankford Hosp., 4940 Frankford Ave., Philadelphia 19124.

Philadelphia; Friends Hosp.; Oct. 3-4, 1974
(2) Adolescence: Development and Intervention (Second Annual Clinical Conference) (74-1-38)
Contact: David B. Arnold, Dir. of Development, Friends Hosp., Roosevelt Blvd. at Adams Ave. Philadelphia 19124.

Philadelphia; **Hahnemann** '74-'75 Academic Year
(1) Rheumatology Tutorial; 8 days repeated Sept 2 - June 26 (75-1-236)
(1) Cardiac Radiology and Angiography Tutorial Course; 15 days, repeated Oct. 7 - June 27 (75-1-221)
(1) Cardiology for the Practicing Physician; Wednesdays; Sept. 4-25; at Marriott Motor Hotel (74-1-11)
(1) Hypertension, Clinical and Laboratory Tutorial; 10 days, repeated Sept. 2 - June 13 (75-1-226)
(1) Cardiac Care Unit Tutorial Course; 15 days, repeated Oct. 7 - June 27 (75-1-218)
(1) Cardio-Hemodynamics Tutorial Course; 15 days, repeated Oct. 7 - June 27 (75-1-219)
(1) Clinical Cardiology-Physiology and Pathophysiology; 15 days repeated Oct. 7 - June 27 (75-1-220)
(1) Clinical Cardiology and Cardiovascular Surgery Tutorial; 15 days, repeated Oct. 7 - June 27 (75-1-222)
(1) Noninvasive Cardiac Techniques Tutorial; 15 days, repeated Oct. 7 - June 27 (75-1-223)
(1) Vector Electrocardiography and Cardiovascular Pharmacology Tutorial; 15 days; repeated Oct. 7 - June 27 (75-1-224)
(1) Dialysis Tutorial Course; 10 days, repeated Sept. 2 - June 13 (75-1-225)
(1) Fluid and Electrolyte Metabolism Tutorial Course; 10 days; repeated Sept. 2 - June 13 (75-1-227)
(1) Fluid, Electrolyte and Acid Base Disorders; at Benjamin Franklin Hotel, Mar. 17-20 (75-1-22)
(1) Gastrointestinal Emergencies; Dec. 2-4; at Marriott Motor Hotel (74-1-12)
(1) Gastrointestinal Endoscopy Tutorial; 5 days, repeated Sept. 9 - June 13 (75-1-237)
(1) Clinical Gastroenterology Tutorial; 6 days, Sept 19-24 and Mar. 20 - Apr. 24 (75-1-238)
(1) General Medicine Reviews; May 5-9; at Marriott Motor Hotel (75-1-23)
(1) Chairman's Medical Grand Rounds; Thursdays, Oct. 3 - May 29 (75-1-239)
(1) Internal Medicine Reviews; Wednesdays, Oct. 2 - Apr. 30 (75-1-240)
(1) Basic Tutorial Course; 60 days, repeated Sept. 9 - June 27 (75-1-241)
(1) Clinical Immunology Tutorial Course; 40 days, repeated Sept. 2 - June 27 (75-1-228)
(1) Clinical Pulmonary Disease Tutorial; 20 days, repeated Sept. 2 - June 27 (75-1-232)
(1) Pulmonary Physiology Tutorial; 20 days, repeated Sept. 2 - June 27 (75-1-233)
(1) Respiratory Intensive Care Tutorial; 20 days; repeated Sept. 2 - June 27 (75-1-234)
(1) Respiratory Inhalation Therapy Tutorial; 20 days, repeated Sept. 2 - June 27 (75-1-235)
(1) Respiratory Intensive Care Workshop; Oct. 14-25 and Apr. 14-25 (75-1-21)
(1) Adult Neurology Tutorial; 60 days, repeated Oct. 7 - June 27 (75-1-229)
(1) Pediatric Neurology Tutorial; 60 days, repeated Oct. 7 - June 27 (75-1-230)
(1) Neuropathology Tutorial; 60 days, repeated Oct. 7 - June 27 (75-1-231)
(1) Orthopedics for the Practicing Physician; Wednesdays, Apr. 2-30 (75-1-20)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann
(1) Psychological Pediatrics Conference; weekly, Sept 19 - May 8 (75-1-212)
(1) Basic Review of Neurology; weekly, Nov. - Jan. and Feb. - Apr. (75-1-213)
(1) Basic Review of Psychiatry; weekly, Nov. - Jan. and Feb. - Apr. (75-1-214)
(1) Human Sexuality; weekly, Mar. 26 - May 28 (75-1-215)

(1) Adolescence and the Youth Culture; weekly, Mar. 19 - May 21 (75-1-216)
Contact: Richard Hicks, M.D., Dept. of Mental Health Sciences, Hahnemann
(1) Psychiatric Sun Seminar in Guadalupe; Nov. 16-24 (74-1-76)
Contact: Richard Newman, M.D., Dept. of Mental Health Sciences, Hahnemann

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Philadelphia; **Institute;** '74-'75 Academic Year
(1) Advances in Psychiatry & the Behavioral Sciences, 1st Thursdays, Sept. June (75-1-78)
(1) Advances in Psychiatry & the Behavioral Sciences, Alternate Fridays, Jan. - May at Philadelphia St. Hosp. (75-1-79)
(1) Films and Human Personality; 1st Saturdays Oct. - Mar. (75-1-80)
(1) Literature and Human Personality; Last Tuesdays Sept. - Mar. (75-1-81)
(1) Practical Issues in the Law for Psychiatrists; Wednesdays Oct. 23 - Nov. 20 (74-1-29)
(1) Professional Management and Economics of Psychiatric Practice; Mondays Sept. 23 - Oct. 14 (74-1-30)
(1) Psychopharmacology 1974; Mondays Oct. 21 - Dec. 9 (74-1-31)
(1) Review of Basic Psychiatry; Thursdays Oct. 3 - Dec. 12 (74-1-32)
Contact: Peter B. Bloom, M.D., Dir., Cont. Educ. in Psychiatry Institute
(1) Medical Hypnosis; Wednesdays, Oct. 2 - Mar. 5 (75-1-292)
(1) Doctor and the Sexual Revolution; Thursdays, Oct. 10 - Dec. 19 (74-1-93)
(1) Treating the Whole Child: A Seminar for Pediatricians; Wednesdays, Sept. 25 - Nov. 27 (74-1-94)
Contact: Sydney E. Pulver, M.D., Dir., Phys. Educ. Project, Institute

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Philadelphia; **Jeanes**; '74-'75 Academic Year
(1) Anemia - Differential Diagnosis; Wednesdays, Apr. 2 - May 7 (75-1-89)
(1) Diagnosis and Treatment of Arrhythmia; Wednesdays, Feb. 19 - Mar. 26 (75-1-88)
(1) Cancer Detection in Office Practice; 5 consecutive Wednesdays, repeated Sept. - Apr; at Amer. Oncologic Hosp. (75-1-86)
(1) Medical Oncology for Practicing Physicians; Wednesdays, Sept. 4 - Oct. 9 (74-1-36)
(1) New Diagnostic Modalities in Radiology; Wednesdays, May 14 - June 18 (75-1-90)
(1) Pain - Diagnosis and Control; Tuesdays, Oct. 15 - Nov. 19 (74-1-37)
(1) Trends in Pediatric Cancer; Nov. 15-16; at Bellevue-Stratford Hotel (74-1-35)
(1) Renal Disease - 1974; Nov. 20 (74-1-34)
(1) What Is This Skin Disease and How Do I Treat It?; Wednesdays, Jan. 8 - Feb. 12 (75-1-87)
Contact: Joseph M. Winston, M.D., D.M.E., Jeanes Hosp., Philadelphia 19111

Philadelphia; **Jefferson**; '74-'75 Academic Year
(1) Modern Therapeutics; Nov. 20-22, 1974 (74-1-91)
(1) Fiberoptic Colonoscopy - A Multidisciplinary Symposium; Sept. 13-14; at Marriott Motor Hotel (74-1-19)
(1) Mechanisms and Therapy of Cardiac Arrhythmias; by **Amer. Coll. of Cardiology** and Lankenau Hosp.; at Marriott Motel; Sept. 12-14 (74-1-17)
Contact: John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson

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Philadelphia; John F. Kennedy Mem. Hosp; '74-'75 Academic Year
(1) Continuing Education Program; by **Hahnemann** (75-1-77)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

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Philadelphia; **MCP**; '74-'75 Academic Year
(1) Preceptorships for Practicing Physicians (in sub specialties); scheduled as convenient (75-1-211)
Contact: Gerald H. Escovitz, M.D., Assoc. Dean, MCP

Philadelphia; Philadelphia Co. Med. Soc.; Sept. 24-25, 1974
(1) Laboratory and Clinical Investigative Techniques in Rheumatology; by Eastern Pa. Arthritis Foundation and **PAFP**(74-1-83)
Contact: H. Ralph Schumacher, M.D., Arthritis Foundation, 331 S. Juniper St., Philadelphia 19107

Philadelphia, Philadelphia Gen. Hosp.; '74-'75 Academic Year
(1) Dermatology Staff Conference; Thursdays; by **U. of Pa.** (75-1-278)
(1) Neuroradiology Clinical Correlation Conference; Wednesdays; by **U. of Pa.** (75-1-279)
(1) PM&R Teaching Conference and Journal Club; Thursdays; by **U. of Pa.** (75-1-280)
(1) PM&R & Psychiatric Conference; Mondays; by **U. of Pa.** (75-1-281)
(1) Prosthetic - Orthotic Conference; fourth Thursdays; by **U. of Pa.** (75-1-282)
(1) Psychiatry Departmental Academic Seminar; Tuesdays; by **U. of Pa.** (75-1-283)
(1) Surgical Pathology Conference; first Tuesdays; by **U. of Pa.** (75-1-284)
(1) Mortality/Morbidity Conference; fourth Tuesdays; by **U. of Pa.** (75-1-285)
(1) Tumor Conference; Tuesdays; by **U. of Pa.** (75-1-286)
(1) Weekly Psychiatric Case Conference; Wednesdays; by **U. of Pa.** (75-1-287)
Contact: Henry G. Sparks, Coordinator, Cont. Educ. Program, U. of Pa.

Philadelphia; Presbyterian - Univ. of Pa. Med. Center; Oct. 30, 1974
(2) Current Practical Approaches to Common Medical Problems (74-1-39)
Contact: Myron Frederick, M.D., Dir. Cont. Educ., Presbyterian - Univ. of Pa. Med. Center, 51 N. 39th St., Philadelphia 19104

Philadelphia; **Temple**; '74-'75 Academic Year
(1) Anesthesiology Seminar; Thursdays (75-1-190)
(1) Anesthesiology Basic Science Lecture; Wednesdays (75-1-191)
(1) Anesthesiology Case Conference, Thursdays (75-1-192)
(1) Thrombohemorrhagic Conference; Fridays (75-1-165)
(1) Cardiac Arrhythmia Conference; Thursdays (75-1-160)
(1) Cardiac Catheterization Conference; Fridays (75-1-164)
(1) Chest Conference; Wednesdays (75-1-158)
(1) Rheumatology Conference; Thursdays (75-1-159)
(1) Infectious Disease Clinical Microbiology Conference; Thursdays (75-1-161)
(1) Pulmonary Grand Rounds; Fridays (75-1-162)
(1) G. I. Conference; Fridays (75-1-163)
(1) Clinical Dermatology Conference; Thursdays; at Skin and Cancer Hosp. (75-1-174)
(1) Office Dermatology; May 14 (75-1-16)
(1) Office Endocrinology; May 21 (75-1-13)
(1) Preceptor Program in Emergency Room Medicine; Apr. 28 - May 16 (75-1-146)
(1) Socratic Seminars; subject - place - format chosen by applicant (75-1-151)
(1) Recent Advances in Medicine; weekly, Oct. 16 - Dec. 4 (74-1-66)
(1) Hepatology Conference; Mondays (75-1-154)
(1) Endocrine-Metabolic Conference; Tuesdays (75-1-155)
(1) CPC/Medicine; Wednesdays (75-1-156)
(1) Medical Grand Rounds; Wednesdays (75-1-157)
(1) Musculoskeletal Problems As Seen in Office Practice; Apr. 16 (75-1-15)
(1) Peripheral Vascular Disease Symposium; Nov. 15-16; at Holiday Inn (74-1-68)
(1) New Developments in Pulmonary Embolism and Venous Thrombosis; Mar. 12 (75-1-153)
(1) Management of Benign Intractable Pain; May 7 (75-1-14)
(1) Human Sexuality and Related Problems; Mar. 28-29 (75-1-12)
(1) Neuroradiology Conference; Tuesdays (75-1-182)
(1) Grand Rounds in Neurosurgery; Fridays (75-1-183)
(1) Neurology Conference; Tuesdays (75-1-181)
(1) Ob Gyn Grand Rounds; Mondays (75-1-169)
(1) Ob Gyn Postgraduate Program; Wednesdays (75-1-170)
(1) The Impact of Abortion on Health Care (17th Isadore Forman Course): Nov. 6 (74-1-67)
(1) Hematology-Oncology Conference; Mondays (75-1-245)
(1) Tumor Conference; Thursdays (75-1-175)
(1) Basic Science Seminar; Wednesdays; at Fels Research Inst. (75-1-176)
(1) Orthopedic Surgery Grand Rounds, Wednesdays (75-1-193)
(1) Fracture Conference; Tuesdays (75-1-194)
(1) Anatomy Conference and Class; Thursdays (75-1-195)
(1) Orthopedic Radiology; Saturdays (75-1-196)
(1) Orthopedic Surgery Basic Science Conference; Saturdays (75-1-197)
(1) Patient Care Mortality and Morbidity Conference (Orthopedic Surgery); Saturdays (75-1-198)
(1) Microsurgery Ophthalmologic Workshops; Spring 1975; at Sugar Loaf Conference Center (75-1-150)
(1) Chevalier Jackson Course in Bronchoesophagology; Oct. 28 - Nov. 8 (repeat) Feb. 3-14 (75-1-46)
(1) Pediatric Grand Rounds; Tuesdays and Fridays; at St. Christopher's Hosp. for Children (75-1-171)
(1) Pediatric Conference; Thursdays; at St. Christopher's Hosp. for Children (75-1-172)
(1) Pediatric Ophthalmology Symposium; May 8-9; at Coll. of Phy. of Philadelphia (75-1-17)
(1) Pediatric Cardiology Conference; Fridays; at St. Christopher's Hosp. for Children (75-1-173)
(1) 24th Annual Pediatric Seminar; May 13-16; at Coll. of Phys. of Philadelphia (75-1-18)
(1) Hemiplegic Rehabilitation; Apr. 17-18 (75-1-148)
(1) Concepts and Implications of Sensory Feedback Therapy; May 15-16 (75-1-149)
(1) Frontiers of Psychotherapy; Mar. 13-14; at Albert Einstein Med. Center (75-1-147)
(1) Rehabilitation Chairman's Rounds; Tuesdays (75-1-178)
(1) Electrodiagnostic Rounds; Thursdays (75-1-179)
(1) Orthotic Rounds; Tuesdays (75-1-180)
(1) Grand Rounds in Psychiatry; First Fridays (75-1-177)
(1) Neuroradiology; Tuesdays (75-1-184)
(1) Pediatric Radiology; Wednesdays (75-1-185)
(1) Urologic Radiology; alternate Thursdays (75-1-186)
(1) Angiography; Fridays (75-1-187)
(1) Staufer Lecture (Radiology); Apr. 23 (75-1-188)
(1) Diagnostic Ultrasound Training Course-Introductory; Sept. 9-13

(repeated Dec. 9-13, Mar. 3-7, June 2-6); at Episcopal Hosp. (75-1-143)
(1) Advanced Diagnostic Ultrasound Training Course in Abdominal Scanning; Oct. 21-25 (repeated Jan. 13-18, Apr. 7-11); at Episcopal Hosp. (75-1-144)
(1) Advanced Diagnostic Ultrasound Training Course in Echocardiography; Nov. 11-15 (repeated Feb. 10-14, May 5-9); at Episcopal Hosp. (75-1-145)
(1) Sports Medicine Clinics; weekly, Apr. (75-1-152)
(1) Basic Science (Surgery) Review; Tuesdays (75-1-166)
(1) Clinical Pathology Radiology Conference; Wednesdays (75-1-167)
(1) Surgical Morbidity Conference; Saturdays (75-1-168)
(1) Urologic Radiology Conference; Mondays (75-1-189)
Contact: Albert J. Finestone, M.D., Assistant Dean for C.M.E., Temple.

Philadelphia; **U. of Pa.** Hosp.; '74-'75 Academic Year.
(1) Anesthesia Case Conference; Thursdays (75-1-273)
(1) Angiography Conference; second Wednesdays (75-1-274)
(1) Cardiology Conference; Thursdays (75-1-275)
(1) Neuroradiology Conference; Saturdays (75-1-276)
(1) Surgical Grand Rounds; Saturdays (75-1-277)
(1) Suburban Pathology Society; first Wednesdays at Montgomery Co. Med. Soc. (75-1-289)
(1) Pathology Society of Philadelphia; second Thursdays; at Coll. of Phys. (75-1-288)
Contact: Henry G. Sparks, Coordinator, Cont. Educ. Program, U. of Pa.

Philadelphia; Wills Eye Hosp., '74-'75 Academic Year
(1) Third Annual Course on Oculo-Plastic Surgery; by **PAO&O**; Apr. 24-26 (75-1-8)
Contact: Gerard Shannon, M.D., Dir. Oculo-Plastic Serv., Wills Eye Hosp., 16th & Spring Garden Sts., Philadelphia 19130
(1) Diagnosis and Management of Glaucoma; by **PAO&O**; Apr. 10-12 (75-1-7)
Contact: George Spaeth, M.D., Dir., Glaucoma Serv., Wills Eye Hosp.; 16th and Spring Garden Sts., Philadelphia 19130

Pittsburgh; **Mercy**; '75-'76 Academic Year
(1) Anesthesiology Basic Science Lectures; Wednesdays (75-1-75)
(1) Cardiology Seminars; Wednesdays (75-1-74)
(1) Seminars in Medicine; Saturdays (75-1-73)
(1) Mercy Day Scientific Conference; Sept. 20, 1974 (74-1-5)
(1) Otolaryngology and Maxillofacial Conference; Saturdays (75-1-76)
(1) Concepts in Soft Tissue Surgery; Jan. 27-31, 1975. (75-1-3)
Contact: John J. Kenny, M.D., Chrm., Cont. Med. Educ., Mercy Hosp., 1400 Locust St., Pittsburgh 15219.

Pittsburgh; North Hills Passavant Hosp.; Sept. 25, 1974 - May 22, 1975
(1) Continuing Education for Physicians; by **Pitt.**; monthly (75-1-115)
Contact: Herbert Anderson, M.D., North Hills Passavant Hosp., 9100 Babcock Blvd., Pittsburgh, 15237

Pittsburgh; **PMS**; Nov. 15-16, 1974
(2) Medical Practice Management; at Chatham Center (74-1-85)
Contact: LeRoy Erickson, Dir. of Educ. Activities, Cncl. on Educ. & Science, PMS.

Pittsburgh; **Pitt.**; '74-'75 Academic Year
(1) Tri State Meeting of **ACP**; Sept. 27-28 (74-1-20)
(5) Lunch Box Theatre; Wednesdays (75-1-128)
(1) Seminars for the Practicing Physician; Wednesdays (75-1-129)
(1) Seminars in Clinical Cardiology; Wednesdays (75-1-130)
(1) Practical Clinical Dermatology; Sept. 12-14; at Chatham Center (74-1-46)
(1) Internal Medicine Recertification Review Course; Sept. 18 - Oct. 23 (74-1-47)
(1) Refresher Course for Family Physicians; Sept. 19-22; at William Penn Hotel (74-1-48)
(1) Diabetes Day; Sept. 25 (74-1-49)
(1) Diseases Due to Immune Mechanisms; Oct. 3-6; at William Penn Hotel (74-1-50)
(1) Regional Bi-State Meeting of **ACP**; Oct. 11-12; at Montefiore Hosp. (74-1-51)
(1) Seminar on Family Planning; Oct. 17; at Magee-Women's Hosp. (74-1-52)
(1) Clinical Neuro-otolaryngology; at William Penn Hotel; Oct. 24-26 (74-1-55)
(1) Second Ob/Gyn Anesthesia Symposium; Nov. 2; at Grad. Sch. of Public Health (74-1-56)
(1) Surgical Anatomy and Techniques of the Temporal Bone; Nov. 3-9; at Eye and Ear Hosp. (74-1-57)
(1) Use of Staplers in Surgery; Nov. 18-19; at Montefiore Hosp. (74-1-58)
(1) Diagnostic and Operative Laparoscopy; Dec. 5-6; at Magee-Women's Hosp. (74-1-59)
(1) Applied Surgical Anatomy; Jan. 6 - Feb. 14 (75-1-131)
(1) The Law and the Physician; Wednesdays, Jan. 8 - Mar. 26 (75-1-132)
(1) Biochemical Mechanisms of Disease; Tuesdays, Jan. 14 - Apr. 8 (75-1-133)
(1) Anatomy and Surgery of the Nose; Feb. 9-15; at Eye and Ear Hosp. (75-1-134)
Contact: William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt.

Pittsburgh; Pittsburgh Otological Soc.; '74-'75 Academic Year
(1) Otolaryngology Conferences; Four Single Days; by **PAO&O** (75-1-55)
Contact: Herman Felder, M.D., Secy., Pittsburgh Otological Soc., 3600 Forbes Ave., Pittsburgh 15213

Pittsburgh; Shadyside Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly (75-1-117)
Contact: William J. Garner, M.D., Shadyside Hosp., Centre Ave., Pittsburgh 15232

Pittsburgh; St. Clair Mem. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly (75-1-116)
Contact: W. Lawrence Wilson, M.D., Chrm., Med. Educ. Cmte., St. Clair Mem. Hosp., 1000 Bower Hill Rd., Pittsburgh 15243

Pittsburgh; **St. Francis**; '74-'75 Academic Year
(1) Medical Grand Rounds; Wednesdays, Aug. 1 - June 15 (75-1-139)
(1) 19th Medical Horizons; Dec. 6 (74-1-61)
(1) 20th Medical Horizons; Dec. 13 (74-1-62)
(1) Ob/Gyn Conference; First and Third Wednesdays, Sept. 9 - June 30 (75-1-140)
(1) PM & R Grand Rounds; Wednesdays, Sept. 3 - June 30 (75-1-141)
(1) Pulmonary Disease Seminar; Sept. 5-6 (74-1-63)
(1) Psychological Aspects of Families Seen by Practicing Physicians, Obstetricians and Pediatricians; Tuesdays, Oct. 1 - Dec. 17 (74-1-64)
(1) Grand Surgical Ward Rounds; Fridays, Sept. 3 - June 30 (75-1-42)
Contact: Joseph A. Marasco, Jr., M.D., Dir. of Cont. Educ., St. Francis Gen., Pittsburgh 15201

Pittsburgh; St. John's Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly; alternately at St. John's Gen. and Suburban Gen. Hosps. (75-1-37)
Contact: R. J. Wojciak, D.O. St. John's Gen. Hosp., 3339 McClure Ave., Pittsburgh 15212.

Pittsburgh; **St. Margaret**; '74-'75 Academic Year
(1) Arthritis and the Rehabilitation Team (75-1-56)
(1) Cardiology Conferences; Alternate Fridays (75-1-57)
(1) Community and Family Practice Seminars (75-1-58)
(1) Continuing Medical Education and Postgraduate Lectures (75-1-59)
(1) Neurology Conferences; 2nd and 4th Fridays (75-1-60)
(1) OB-GYN Conference; Alternate Tuesdays (75-1-61)
(1) Pediatric Conference; Alternate Tuesdays (75-1-62)
(1) Psychiatry Seminars in Family Practice (75-1-63)
(1) Radiology Conferences (75-1-64)
(1) Rehabilitation Team in Action (75-1-65)
(1) Rheumatology Grand Rounds; Monthly (75-1-66)
(1) Rheumatology for the Orthopedic Surgeon (75-1-67)
(1) Rheumatology-Pathology Review (75-1-68)
(1) Rheumatology-Radiology Review (75-1-69)
(1) Selected Topics in Rheumatology (75-1-70)
(1) Surgery Conference (75-1-71)
(1) Workshop in Rheumatology and Orthopedics (Surgical Indications); 6 days a mo. (75-1-72)
Contact: Paul W. Dishart, M.D., Coordinating Director, CME, St. Margaret

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Pittsburgh; Staunton Clinic: '74-'75 Academic Year
(1) Seminar on Patient Care for Physicians; by **Pitt**; 13 weeks, starting Sept. 11 (74-1-87)
(1) Seminar on Psychotherapy for Psychiatrists; by **Pitt**; 10 weeks (74-1-88)
Contact: Rex A. Pittenger, M.D., Dir., Staunton Clinic, 3601 Fifth Avenue, Pittsburgh 15261.

Pittsburgh; Suburban Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; monthly; alternately at Suburban Gen. Hosp. and St. John's Gen. Hosp. (75-1-137)
Contact: Wayne Greenburg, M.D., Suburban Gen Hosp., S. Jackson Ave., Pittsburgh 15202

Pottsville; Good Samaritan Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; monthly, Sept. 19 - May 29 (75-1-293)
Contact: Office of Cont. Educ., U. of Pa.

Pottsville; Pottsville Hosp. & Warne Clinic; '74-'75 Academic Year
(1) Postgraduate Seminars for Physicians; by **Jefferson**; first Thursdays Sept 5 - June 5 (75-1-1)
Contact: E. W. Cubler, M.D., D.M.E., Pottsville Hosp. and Warne Clinic, 420 S. Jackson St., Pottsville 17901.

Reading; Berks Co. Med. Soc.; '74-'75 Academic Year
(1) Continuing Medical Education Program; at Medical Hall; by **PAFP** and **Reading**; first three Wednesdays each month (74-1-86)
Contact: Leonard M. Del Vecchio, M.D., Chrm., Cont. Med. Educ. Comm., Berks Co. Med. Soc. 429 Walnut St., Reading 19601

Reading Eye, Ear, Nose and Throat Soc.; '74-'75 Academic Year
(1) Combined EENT Conferences; by **PAO&O** monthly, Sept. - Apr. (75-1-54)
Contact: Donald Burns, M.D., Secy., Reading Eye, Ear, Nose and Throat Soc., 1500 Penn Ave. Wyomissing 19610

Roaring Spring; Nason Hosp.; Sept 3, 1974 - June 5, 1975
(1) Continuing Education for Physicians; by **Pitt.**; First Tuesdays (75-1-118)
Contact: Marion A. Morelli, M.D., Chrm. Educ. Cmte., Nason Hosp., Roaring Spring 16673

Rochester; Sept 18, 1974 - May 21, 1975
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Beaver Co. and Aliquippa Hosps., Third Wednesdays (75-1-119)
Contact: Mrs. Susan Frey, Exec. Secy., Beaver Co. Med. Soc., 350 Adams St., Rochester 15074.

Sayre; **Packer** '74-'75 Academic Year
(1) Surgical Grand Rounds; Saturdays (75-1-268)
(1) Tumor Conference; second and fourth Thursdays (75-1-269)
(1) Clinical Pathological Conference; third Wednesdays (75-1-270)
(1) Medical Grand Rounds; Fridays (75-1-271)
Contact: Paul C. Royce, M.D., Ph. D., D.M.E., Packer

St. Mary's; Sept. 4 - Nov. 6, 1974
(1) Continuing Education for Physicians; by **Pitt.** and Elk-Cameron Co. Med. Soc., at Andrew Kaul Mem. Hosp.; weekly (74-1-60)
Contact: B. L. Coppolo, M.D., 121 Arch St., St. Marys 15857

Sharon Gen. Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly; at Tumor Clinic (75-1-135)
Contact: Thomas V. Murray, M.D., Dir., Tumor Clinic, Sharon Gen. Hosp., East State St., Sharon, 16147
(1) Continuing Education for Physicians; by **Pitt.**; first and third Wednesdays (75-1-120)
Contact: Allen H. Holt, M.D., Mercer Co. Med. Soc., 32 Jefferson Ave., Sharon 16146

Sunbury; Sept 11 - Nov. 27, 1974
(1) Continuing Education Program; by **Hahnemann** and Northumberland and Union County Medical Societies; at Community Hosp. (75-1-9)
Contact: Willard W. Christman, M.D., Dir. of Med. Educ., Community Hosp., Sunbury 17801

Titusville; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt.**; alternately at Titusville, Franklin and Oil City Hosps. (75-1-113)
Contact: Robert M. Pilewski, M.D., Venango Co. Med. Soc., 9 Glenview Ave., Oil City 16301

Uniontown Hosp.; Sept. 25, 1974 - May 28, 1975
(1) Continuing Education for Physicians; by **Pitt.**; Fourth Wednesdays (75-1-121)
Contact: Walter Lion, Exec. Secy., Fayette Co. Med. Soc., 30 Delaware Ave., Uniontown 15401

University Park; '74-'75 Academic Year
(1) Chariman's Medical Grand Rounds (video-cassettes); at Ritenour Health Center; by **Hahnemann**; weekly (75-1-243)
Contact: John A. Hargleroad, II, M.D., Ritenour Health Center, Pa. State Univ., University Park 16802

Washington Hosp.; '74-'75 Academic Year
(1) Continuing Education for Physicians; by **Pitt**; monthly (75-1-122)
Contact: John Pirris, M.D., Chrm., Staff Educ. Cmte., Washington Hosp., 155 Wilson Ave., Washington 15301

Wellsboro; Oct. 16, 1974 - June 18, 1975
(1) Postgraduate Seminars for Physicians; at Soldiers and Sailors Mem. Hosp.; by **Jefferson** (75-1-4)
Contact: Mr. Ralph C. Antrim, Admin., Soldiers and Sailors Mem. Hosp., Wellsboro 16901

Wilkes Barre; Luzerne Co. Med. Soc.; Sept. 11 - Nov. 13, 1974
(1) Continuing Education Program; by **Hahnemann**; monthly (74-1-18)
Contact: Leona O. Franey, Exec. Secy., 130 S. Franklin St., Wilkes-Barre 18701

Wilkes-Barre; Mercy Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **Geisinger**; Sept. 5, Oct. 3 and 17, Nov. 14 (74-1-75)
Contact: J. P. Brennan, M.D., D.M.E., Mercy Hosp., Wilkes-Barre 18702

Wilkes-Barre; Wyoming Valley Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **Hahnemann**; weekly, Sept. 11 - May 28 (75-1-48)
Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ., Hahnemann

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Williamsport; Williamsport Hosp.; '74-'75 Academic Year
(1) Continuing Education Program; by **U. of Pa.**; Second Fridays, Sept. - June (75-1-43)
(1) Medical and Surgical Grand Rounds; by **U. of Pa.**; Saturdays, Sept. 7 - Dec. 28 (74-1-23)
Contact: Herman W. Rannels, M.D., Vice President and Med. Dir., Williamsport Hosp., 777 Rural Ave., Williamsport 17701

York Hosp.; Sept. 12, 1974 - Apr. 24, 1975
(1) Seminars in Continuing Medical Education; by **Jefferson**; weekly (75-1-44)
Contact: Merle S. Bacastow, M.D., Vice Pres. Med. Affairs, York.

ANNUAL MEETINGS

ACP Tri-State Meeting - September 27-28, 1974 - University of Pittsburgh

ACS-Central Pennsylvania Chapter - October 25, 1974 - Host Inn, Harrisburg

ACS-Eastern Pennsylvania Chapter - November 13, 1974 - Holiday Inn East, Bethlehem

Allergy Association, Pennsylvania - June 1975 - Hershey

Anesthesiologists, Pennsylvania Society of - May 2-4, 1975 - Penn Harris Motor Inn, Camp Hill

Clinical Pathologists, Pennsylvania Association of - May 1975 - Hotel Hershey

Colon and Rectal Surgeons, Pennsylvania Society of - (Quarterly Meeting) September 12, 1974 - Union League, Philadelphia

Dermatology, Pennsylvania Academy of - September 20-22, 1974 - Seven Springs, Champion

Emergency Physicians, Pennsylvania Chapter of American College of - April 24-26, 1975 - University Hilton Hotel, Philadelphia

Family Physicians, Pennsylvania Academy of - May 6-10, 1975 - Seven Springs, Champion

Internal Medicine, Pennsylvania Society of - March 1975 - Philadelphia

Keystone State Medical Society - March 23, 1975 - Holiday Inn Town, Harrisburg

Ophthalmology and Otolaryngology, Pennsylvania Academy of - April 22-24, 1975 - Bedford Springs Hotel, Bedford

Orthopaedic Society, Pennsylvania - October 24-25, 1974 - Host Inn, Harrisburg

Pennsylvania Medical Society - (Annual Session) October 9-12, 1974 - William Penn Hotel, Pittsburgh

Physical Medicine and Rehabilitation, Pennsylvania Academy of - October 25, 1974 - Host Inn, Harrisburg

Psychiatric Society, Pennsylvania - (Fall Meeting) October 25, 1974 - Host Inn, Harrisburg; (Annual Meeting) April 11-13, 1975 - Philadelphia

Radiological Society, Pennsylvania - May 15-18, 1975 - Host Corral, Lancaster

Robert H. Ivy Society (Plastic Surgery) - October 25, 1974 - Host Inn, Harrisburg

Thoracic Surgery, Pennsylvania Association for - September 13-15, 1974 - Hotel Hershey

CALENDAR

A quick reference to Category One continuing medical education opportunities in Pennsylvania by date.

SEPTEMBER

3 Renal Disease—Part I; at Citizens Gen. Hosp. New Kensington (74-1-16)
4 Hematology; at Holiday Inn, New Kensington (74-1-15)
4 Cardiology for the Practicing Physician; by Hahnemann, Philadelphia (74-1-11)
4 Prostaglandins; Berks Co. Med. Soc., Reading (74-1-86)
5 Glands Not to Monkey With; at Pottsville Hosp. (75-1-1)
5 Practical Uses of Ultrasound in Aiding the Family Practitioner, Mercy Hosp., Wilkes Barre (74-1-75)
5-6 • Pulmonary Disease Seminar; at St. Francis, Pittsburgh (74-1-63)
7 Respiratory Failure; at Williamsport Hosp. (74-1-23)
9-13 • Diagnostic Ultrasound Training Course-Introductory; by Temple, Philadelphia (75-1-143)
10 Renal Disease—Part II; at Citizens Gen. Hosp. New Kensington (74-1-16)
11 Cardiology for the Practicing Physician; by Hahnemann, Philadelphia (74-1-11)
11 Hypertension; Berks Co. Med. Soc., Reading (74-1-86)
11 Diagnosis of Thyroid Disease; at Sunbury Community Hosp. (75-1-9)
11 Chronic Liver Disease; Luzerne Co. Med. Soc., Wilkes Barre (74-1-18)
12-14 Mechanisms and Therapy of Cardiac Arrhythmias; by Jefferson and ACC, Philadelphia (74-1-17)
12-14 • Practical Clinical Dermatology; by Pitt, Pittsburgh (74-1-46)
13 Cancer Workshop; at Williamsport Hosp. (75-1-43)
13-14 • Fiberoptic Colonscopy - A Multidisciplinary Symposium; by Jefferson, Philadelphia (74-1-19)
14 Intrauterine Growth; at Williamsport Hosp. (74-1-23)
17 VD in Daily Practice; Monongahela Div., Monogahela Valley Hosp (75-1-42)
18 The Retrieval of Medical Information; at Allentown Hosp. (75-1-38)
18 Malabsorption - What's New; at Holy Redeemer Hosp, Meadowbrook (75-1-19)
18 Cardiology for the Practicing Physician; by Hahnemann, Philadelphia (74-1-11)
18 Anemias—Office Diagnosis, Testing and Management; at Shadyside Hosp., Pittsburgh (75-1-117)
18 Antibiotics-Mechanism of Action and How to Select; at Suburban Gen. Hosp., Pittsburgh (75-1-137)
18 Basic Immunology; Berks Co. Med. Soc., Reading (74-1-86)
18 Cardiac Drugs - Use & Abuse; at Sharon Gen. Hosp. (75-1-120)
18-23 • Internal Medicine Recertification Review Course; at Pitt (74-1-47)
19 EENT Problems in Family Practitioners Office; at Polyclinic Hosp., Harrisburg (75-1-124)
19 Fiberoptics—Colonoscopy and/or Upper GI Tract; at Hazleton (75-1-47)
19 Clinical Approach to Coagulation Mechanisms; at Good Samaritan Hosp., Pottsville (75-1-293)
19-22 Refresher Course for Family Physicians; by Pitt, Pittsburgh (74-1-48)
20 Mercy Day Scientific Conference; at Pittsburgh Mercy (74-1-5)
20-23 Advances in Dermatology - 1974; (Dermatology); at Seven Springs, Champion (74-1-10)
21 Immunotherapeutic Approach to Malignant Melanoma; at Williamsport Hosp. (74-1-23)
24-25 Laboratory and Clinical Investigative Techniques in Rheumatology; at Philadelphia Co. Med. Soc. (74-1-83)
25 Cardiology for the Practicing Physician; by Hahnemann, Philadelphia (74-1-11)
25 Diabetes Day; at Pitt (74-1-49)
25 Management of Difficult Diabetic; at Sunbury Community Hosp. (75-1-9)
25 Lupus, Gout; at Washington Hosp. (75-1-122)
26 Cutaneous Manifestations of Systemic Diseases: at Hazleton St. Gen. Hosp. (75-1-47)
27-28 • Tri-State Mtg. of ACP; at Pitt. (74-1-20)
27-28 Role of Practitioner in Treatment and Preventative Management of Cardiovascular Disease; by AHA, Hershey (74-1-92)
28 Systemic Lupus Erythematosus; at Williamsport Hosp. (74-1-23)
30-Oct 3 • Physiologic Approaches to the Diagnosis and Treatment of GI Disease; by ACP, Philadelphia (74-1-3)
30-Oct 4 • Mechanisms and Management of Clinical Pulmonary Disease; by ACP, Philadelphia (74-1-6)

OCTOBER

1 Contemporary Trends in Psychopharmacology: A Comprehensive Review; at Haverford St. Hosp. (74-1-8)
2 Immunizations in Childhood and for Travel; at Sacred Heart Hosp; Allentown (75-1-38)
2 The Comatose Patient; at Easton Hosp. (75-1-10)
2 Pediatrics: (Pitt.); at Holiday Inn, New Kensington (74-1-15)
2 Social Development of the Infant and Young Child; Berks Co. Med. Soc.; Reading (74-1-86)
2 Cardiopulmonary Resuscitation; at Sharon Gen. Hosp. (75-1-120)
3 Current Aspects of Cardiovascular Disease 1974; Maple Avenue Hosp., DuBois (74-1-13)
3 Hematologic Manifestations of Systemic Diseases; at Hazleton St. Gen. Hosp. (75-1-47)
3 Anemias, Diagnosis and Evaluation; at Pottsville Hosp. (75-1-1)
3 Practical Use of Thyroid Tests in Clinical Practice; Mercy Hosp., Wilkes Barre (74-1-75)
3-6 Diseases Due to Immune Mechanisms; at Pitt. (74-1-50)
5 Evaluation of Stroke Syndromes; at Williamsport Hosp. (74-1-23)
8 • Contemporary Trends in Psychopharmacology: A Comprehensive Review; at Haverford St. Hosp. (74-1-8)
8 Hypertension—Part I; at Citizens Gen. Hosp., New Kensington (74-1-16)
9 Hyperlipidemia, Diagnosis & Treatment; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
9 Pulmonary Function Testing for the Practicing Physicians; Berks Co. Med. Soc. Reading (74-1-86)
9 Diagnosis & Management of Acid Base Disorders; Luzerne Co. Med. Soc., Wilkes-Barre (74-1-18)
10 Lumps in the Breast: at Hazleton St. Gen. Hosp. (75-1-47)
10 Ultrasonic Techniques in Medical Diagnosis; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
11 Small Bowel and Inflammatory Bowel Diseases—Diet Considerations, etc, at Williamsport Hosp (75-1-43)
11-12 Regional Bi State Meeting-ACP; by Pitt., (74-1-51)
12 • Human Sexuality; Norristown State (74-1-74)
12 Systemic Lupus Erythematosus (Part II); at Williamsport Hosp. (74-1-23)
14-25 Workshops in Respiratory Intensive Care; at Hahnemann, Philadelphia (75-1-21)
15 Urinary Tract Infections—Treatment; at Charleroi Div., Monongahela Valley Hosp. (75-1-41)
15 Contemporary Trends in Psychopharmacology: A Comprehensive Review; at Haverford St. Hosp. (74-1-8)
15 Hypertension—Part II; at Citizens Gen. Hosp., New Kensington (74-1-16)
16 Multi-Phasic Health Screening—Pros and Cons; at Allentown Hosp. (75-1-38)
16 • 17th Neuropsychiatric Institute—Biological Considerations in the Treatment of Neuropsychiatric Conditions; at Coatesville V.A. Hosp. (74-1-21)
16 Headache; at Shadyside Hosp., Pittsburgh (75-1-117)
16 Arthritis; at Suburban Gen. Hosp., Pittsburgh (75-1-137)
16 Thyroid Tests and the Treatment of Hyperthyroidism & Hypothyroidism; Berks Co. Med. Soc.; Reading (74-1-86)
16 Acute Infectious Disease; at Sharon Gen. Hosp. (75-1-120)
16 Clinical Evaluation of Renal Function; at Sunbury Community Hosp. (75-1-9)
16 Cancer, Immunotherapy; at Washington Hosp. (75-1-122)
16 Evaluation of Thyroid Disease; at Soldiers & Sailors Mem. Hosp; Wellsboro (75-1-4)
17 Fractures of the Cervical Spine; at Hazleton St. Gen. Hosp. (75-1-47)

KEY:
• Indicates session that will be presented at a specialty level.

(75-1-XX) Numbers in parentheses at the end of the item are code numbers which will be helpful as a reference to find a contact for more information.
See: town, institution and code numbered item in "Announcements" section for complete details.

17 Seminar on Family Planning; by Pitt; at Magee-Women's Hosp., Pittsburgh (74-1-52)
17 Practical Aspects in the Antibiotic Treatment of Pneumonia; Mercy Hosp., Wilkes Barre (74-1-75)
19 Analysis of Problems Associated with the Cuffs on Intratraceal Tubes; at Williamsport Hosp. (74-1-23)
21-25 • Advanced Diagnostic Ultrasound Training Course in Abdominal Scanning; by Temple, Philadelphia (75-1-144)
22 • Contemporary Trends in Psychopharmacology: A Comprehensive Review; at Haverford St. Hosp. (74-1-8)
23 Dermatology for the Non-Dermatologist: at Geisinger, Danville (74-1-24)
24 Infectious Disease Problems for the Practitioners; at Harrisburg (75-1-124)
24 Transfusions—Indications, Reactions and Treatment, Use of Blood Components; at Hazleton St. Gen. Hosp. (75-1-47)
24-26 • Clinical Neuro-otolaryngology; at Pitt. (74-1-55)
25 • Workshop and Lectures on Converting Your Serology Lab tc Microtiter; at Geisinger, Danville (74-1-4)
26 Liver Disease; at Williamsport Hosp. (74-1-23)
28-Nov. 8 Bronchoesophagology; at Temple, Philadelphia (75-1-46)
29 Contemporary Trends in Psychopharmacology: A Comprehensive Review; at Haverford St. Hosp. (74-1-8)
30 Pulmonary Emergencies; at Geisinger, Danville (74-1-41)
30-Nov 1 Innovations in the Diagnosis and Management of Acute Myocardial Infarction; by ACP, Philadelphia (74-1-2)
30 Headaches: Differential Diagnosis and Treatment; at Sunbury Community Hosp. (75-1-9)
30 Ulcerative Colitis, Regional Ileitis; at Washington Hosp., (75-1-122)
31 Recent Advances in Anesthesiology; at Hazleton Gen. Hosp. (75-1-47)
31 Treatment and Management of Diabetes; at Good Samaritan Hosp., Pottsville (75-1-293)

NOVEMBER

2 • Second Ob-Gyn Anesthesia Symposium; at Pitt. (74-1-56)
2 Breast Cancer & Its Complications; at Williamsport Hosp. (74-1-23)
3-9 • Surgical Anatomy and Techniques of the Temporal Bone; by Pitt. (74-1-57)
6 Phases in Adult Life with the Predictable Crises; at Sacred Heart Hosp., Allentown (75-1-38)
6 Plastic Surgery: (Pitt.) at Holiday Inn. New Kensington (74-1-15)
6 • Impact of Abortion on Health Care; at Temple, Philadelphia (74-1-67)
6 Management of the VD Patient in the Private Physician's Office, Berks Co. Med. Soc.; Reading (74-1-86)
6 Congestive Heart Failure; at Sharon Gen. Hosp. (75-1-120)
6 Anemias: at Washington Hosp., (75-1-122)
7 Drug Interactions; at Hazleton St. Gen. Hosp. (75-1-47)
7 Osseous Manifestations of Systemic Diseases; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
7 Alcoholism - The Many Faces of; at Pottsville Hosp. (75-1-1)
8 Gynecology Oncology; at Williamsport Hosp. (75-1-43)
9 Adrenal Disease & Steroid Metabolism; at Williamsport Hosp. (74-1-23)
11-15 • Advanced Diagnostic Ultrasound Training Course in Echocardiography by Temple, Philadelphia (75-1-145)
13 • Annual Scientific Meeting - Eastern Pa. Chapt. A.C.S.; Bethlehem (74-1-22)
13 Clinical Aspects of Pituitary Disease; at Geisinger, Danville (74-1-42)
13 Postgraduate Seminars for Physicians; at Franklin Hosp. (74-1-7)
13 Hyperinsulinism in Diabetes Mellitus; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
13 Arthritities; Berks Co. Med. Soc., Reading (74-1-86)
13 Differential Diagnosis of the Rheumatic Diseases; at Sunbury Community Hosp. (75-1-9)
13 Respiratory Failure: Diagnosis & Management; Luzerne Co. Med. Soc., Wilkes-Barre (74-1-18)
14 Brain Tumors; at Hazleton St. Gen. Hosp. (75-1-47)
14 Diagnosis and Management of Inflammatory Disease of Bowel; Mercy Hosp., Wilkes Barre (74-1-75)
15-16 • Trends in Pediatric Cancer; by Jeanes, Philadelphia (74-1-35)
15-16 Peripheral Vascular Disease Symposium; by Temple; Philadelphia (74-1-68)
15-16 Medical Practice Management; by PMS, Pittsburgh (74-1-85)
16 Workshop on Acid-Base Balance; Lehigh AHEC, Allentown (74-1-28)
16 Physiologic Consequences & Bodily Adaptions to Hyper- and Hypo-carbia; at Williamsport Hosp. (74-1-23)
16-24 Psychiatric Sun Seminar in Guadalupe; Hahnemann, Philadelphia (74-1-76)
18-19 • Use of Staplers in Surgery; by Pitt. (74-1-58)
19 Connective Tissue Diseases (Collagen Diseases); at Monongahela Div., Monongahela Valley Hosp. (75-1-42)
19 Chronic Lung Disease—Part I; at Citizens Gen Hosp., New Kensington (74-1-16)
20 Abuse of Antibiotics in and out of the Hospital; at Allentown Hosp. (75-1-38)
20 • Renal Disease - 1974; at Jeanes, Philadelphia (74-1-34)
20 Thyroid Problems; at Shadyside Hosp., Pittsburgh (75-1-117)
20 Medical Management of Major Psychiatric Illnesses; at Suburban Gen. Hosp., Pittsburgh (75-1-137)
20 Peptic Ulcer Disease; Berks Co. Med. Soc., Reading (74-1-86)
20 Modern Management of Common Skin Disorders; at Sharon Gen. Hosp. (75-1-120)
20 Headaches; at Washington Hosp. (75-1-122)
20 Hematology Refresher Course; at Soldiers & Sailors Mem. Hosp; Wellsboro (75-1-4)
20-22 Modern Therapeutics; by Jefferson, Philadelphia (74-1-91)
21 Gastrointestinal Problems Seen by the Practitioner; at Polyclinic Hosp., Harrisburg (75-1-124)
21 Stroke—Diagnosis and Treatment; at Hazleton St. Gen. Hosp. (75-1-47)
21 Clinical Approach to Endocrinology for the Practicing Physician; Good Samaritan Hosp., Pottsville (75-1-293)
23 Pituitary Disease; at Williamsport Hosp. (74-1-23)
26 Chronic Lung Disease—Part II; at Citizens Gen. Hosp., New Kensington (74-1-16)
27 Acute Abdomen: Diagnosis and Management; at Sunbury Community Hosp. (75-1-9)
30 Diagnostic & Therapeutic Considerations in Mixed Respiratory and Metabolic Acid-Base Problems: at Williamsport Hosp. (74-1-23)

DECEMBER

2-4 Gastrointestinal Emergencies; by Hahnemann, Philadelphia (74-1-12)
3 VD in Daily Practice; at Citizens Gen. Hosp., New Kensington (74-1-16)
4 Cardiac Rehabilitation; at Sacred Heart Hosp., Allentown (75-1-38)
4 Pre- and Post Operative Medical Evaluation and Management; at Easton Hosp. (75-1-10)
4 Hormones & Disorders of the Gastrointestinal Tract; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
4 Treatment of Tuberculosis in 1974; Berks Co. Med. Soc., Reading (74-1-86)
4 Medico-Legal Aspects of Emergency Care; at Sharon Gen. Hosp. (75-1-120)
4 Orthopaedic Conference; at Washington Hosp. (75-1-122)
4 Urology Conference; at Washington Hosp. (75-1-122)
5 The Acute Abdomen: at Hazleton St. Gen. Hosp. (75-1-47)
5 Upper Respiratory Insufficiency in Children; at Pottsville Hosp. (75-1-1)
5-6 • Diagnostic and Operative Laparoscopy; by Pitt. (74-1-59)
6 19th Medical Horizons Program; at St. Francis, Pittsburgh (74-1-61)
7 Drug Interaction; at Williamsport Hosp. (74-1-23)
9-13 • Diagnostic Ultrasound Training Course-Introductory; by Temple, Philadelphia (75-1-143)
11 Use and Misuse of Antibiotics; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
11 Emotional Problems in General Practice; Berks Co. Med. Soc., Reading (74-1-86)
12 Surgery in Peripheral Vascular Disease: at Hazleton St. Gen. Hosp. (75-1-47)
13 20th Medical Horizons Program; at St. Francis, Pittsburgh (74-1-62)
13 Rheumatology Collagen, Vascular Disease; at Williamsport Hosp. (75-1-43)
14 Carcinoma of the Prostate; at Williamsport Hosp. (74-1-23)
17 Alcoholism; at Charleroi Div., Monongahela Valley Hosp. (75-1-41)
18 Common Fractures and Dislocations for the Primary Physician; at Allentown Hosp. (75-1-38)
18 Office treatment of the Alcoholic; at Shadyside Hosp., Pittsburgh (75-1-117)
18 Office Gynecology; at Suburban Gen. Hosp., Pittsburgh
18 Cutaneous Manifestations of Internal Disease; Berks Co. Med. Soc., Reading (74-1-86)
19 Metastic Ca of the Breast—Surgical and Hormonal Treatment; at Hazleton St. Gen. Hosp. (75-1-47)

21 How to Suspect Immune Deficiency Disease; at Williamsport Hosp. (74-1-23)
26 Tuberculosis and Hemoptysis; at Good Samaritan Hosp., Pottsville (75-1-293)
28 Undescended Testicle; Williamsport Hosp. (74-1-23)

1975

JANUARY

6-Feb 14 • Applied Surgical Anatomy; at Pitt. (75-1-131)
8 Gynecology Conference, Psy. Conf.; at Washington Hosp. (75-1-122)
9 Heart Disease in Pregnancy; at Hazleton St. Gen. Hosp. (75-1-47)
9 Bloody Stools; at Pottsville Hosp. (75-1-1)
10 Edema and Hyponatremia; at Williamsport Hosp. (75-1-43)
13-16 • Advanced Diagnostic Ultrasound Training Course in Abdominal Scanning; by Temple, Philadelphia (75-1-144)
15 Tuberculosis; at Allentown Hosp. (75-1-38)
15 Hepatitis—Other Liver Disease; at Shadyside Hosp., Pittsburgh (75-1-117)
15 Differential Dx of Strokes & Immediate Rx; at Suburban Gen. Hosp., Pittsburgh (75-1-137)
15 Cancer Immunology; at Sharon Gen. Hosp. (75-1-120)
15 Office Gynecology; at Soldiers & Sailors Mem. Hosp; Wellsboro (75-1-4)
16 Ca of the Prostate; at Hazleton St. Gen. Hosp. (75-1-47)
21 Newer Diagnostic Techniques - How to & When to Use; at Abington Mem. Hosp. (75-1-5)
21 Diseases Due to Protein Abnormalities; Monongahela Div., Monongahela Valley Hosp. (75-1-42)
22 Internal Medicine Day; at Washington Hosp. (75-1-122)
23 Hyperlipidemias; at Hazleton St. Gen. Hosp. (75-1-47)
23 Headaches: Differential Dx and Treatment; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
27-31 • Concepts in Soft Tissue Surgery; at Pittsburgh Mercy (75-1-3)
28 Newer Diagnostic Techniques - How to & When to Use; at Abington Mem. Hosp. (75-1-5)
30 Hyperuricemia; at Hazleton St. Gen. Hosp. (74-1-47)
30 Symposium on the Kidney; Good Samaritan Hosp., Pottsville (75-1-293)

FEBRUARY

3-14 Bronchoesophagology; at Temple, Philadelphia (75-1-46)
4 Newer Diagnostic Techniques - How to & When to Use; at Abington Mem. Hosp. (75-1-5)
5 Veneral Diseases; at Sacred Heart Hosp., Allentown (75-1-38)
5 Growth & Development - When to Reassure, When to Treat; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
5 Congenital Heart Disease; at Sharon Gen. Hosp. (75-1-120)
5 General and Thoracic Surgery Day; at Washington Hosp. (75-1-122)
6 Problems of Adolescence; at Pottsville Hosp. (75-1-1)
9-15 • Anatomy and Surgery of the Nose; by Pitt., (75-1-134)
10-14 • Advanced Diagnostic Ultrasound Training Course in Echocardiography; by Temple, Philadelphia (75-1-145)
11 Newer Diagnostic Techniques - How to & When to Use; at Abington Mem. Hosp. (75-1-5)
12 Medical Management of Rheumatic Heart Disease; at Sunbury Community Hosp. (75-1-9)
13 Genetic Counselling; at Hazleton St. Gen. Hosp. (75-1-47)
14 Genetics and Genetic Counselling Workshop; at Williamsport Hosp. (75-1-43)
18 Newer Diagnostic Techniques - How to & When to Use; at Abington Mem. Hosp. (75-1-5)
18 Peripheral Vascular Disease—Elective & Emergency Surgery; Charleroi Div., Monongahela Valley Hosp. (75-1-41)
19 Early Detection and Management of Chronic Lung Diseases: at Allentown Hosp. (75-1-38)
19 Immunologic Tests and Interpretations; at ADR Center, St. John's Hosp., Pittsburgh (75-1-137)
19 Office Management of the Diabetic; at Shadyside Hosp., Pittsburgh (75-1-117)
19 Fluid Electrolyte Management; at Sharon Gen. Hosp. (75-1-120)
19 Complications of Pregnancy; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
20 Office Emergencies; at Harrisburg (75-1-124)
20 The Child Asthmatic; at Hazleton St. Gen. Hosp. (75-1-47)
26 Diagnosis and Treatment of Gastrointestinal Hemorrhage; at Sunbury Community Hosp. (75-1-9)
26 X-Ray Conference, Laboratory Conference; at Washington Hosp. (75-1-122)
27 Evaluation of Jaundice; at Hazleton St. Gen. Hosp. (75-1-47)
27 Neurological Complication of Visceral Malignancy; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
27 Endoscopy, Clinical Applications and New Techniques; Good Samaritan Hosp., Pottsville (75-1-293)

MARCH

3-7 • Diagnostic Ultrasound Training Course-Introductory; by Temple, Philadelphia (75-1-143)
5 Endocrinology—Newer Methods of Hormonal Assays and Their Practical Use; at Sacred Heart Hosp.; Allentown (75-1-38)
5 Treatment of Abnormalities of Acid-Base Balance; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
5 Burn Management; at Sharon Gen. Hosp. (75-1-120)
6 Neurologic Emergencies—Dx and Rx; at Hazleton St. Gen. Hosp. (75-1-47)
6 Acute Management of Burns; at Pottsville Hosp. (75-1-1)
12 Jaundice: Differential Dx and Management; at Holy Redeemer Hosp., Meadowbrook (75-1-11)
12 New Developments in Pulmonary Embolism and Venous Thrombosis; at Temple, Philadelphia (75-1-153)
12 Jaundice: Differential Diagnosis and Management: at Sunbury Community Hosp. (75-1-9)
13 Hospital Infections; at Hazleton St. Gen. Hosp. (75-1-47)
13-14 • Frontiers of Psychotherapy; by Temple, Philadelphia (75-1-147)
14 G.U. Tract Infection; at Williamsport Hosp. (75-1-43)
17-20 Fluid, Electrolyte and Acid Base Disorders; by Hahnemann, Philadelphia (75-1-22)
19 Peptic Ulcer Disease—Recent Aspects; at Allentown Hosp. (75-1-38)
19 Evaluation of Jaundice and Liver Function Tests; at ADR Center, St. John's Hosp., Pittsburgh (75-1-137)
19 Proteinuria—Its Significance; at Shadyside Hosp., Pittsburgh (75-1-117)
19 Skeletal Stress & Strain—Management of Acute Pain; at Sharon Gen. Hosp. (75-1-120)
19 Common Ear Problems; at Soldiers & Sailors Mem. Hosp; Wellsboro (75-1-4)
20 Lupus Erythematosis; at Hazleton St. Gen. Hosp. (75-1-47)
26 Diagnosis and Management of Acid Base Disorders; at Sunbury Community Hosp. (75-1-9)
27 Hand Injuries; at Hazleton St. Gen. Hosp. (75-1-47)
27 Hyperlipidemia; Good Samaritan Hosp., Pottsville (75-1-293)
28-29 Human Sexuality and Related Problems; by Temple, Philadelphia (75-1-12)

APRIL

2 Genetic Counseling (What It Is, Who Needs It, and How to Get It); at Sacred Heart Hosp., Allentown (75-1-38)
2 Cardiac Resuscitation; at Easton Hosp. (75-1-10)
2 Diarrhea; at Sharon Gen. Hosp (75-1-120)
3 Evaluation and Uses of New Antibiotic Medications; at Pottsville Hosp. (75-1-1)
7-11 • Advanced Diagnostic Ultrasound Training Course in Abdominal Scanning; by Temple, Philadelphia (75-1-144)
9 Treatment of Peripherovascular Disorders; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
9 Common Skin Infections; at Sunbury Community Hosp. (75-1-9)
10 Renal Calculi; at Hazleton St. Gen. Hosp. (75-1-47)
10-12 • Diagnosis & Management of Glaucoma; at Wills Eye Hosp., Philadelphia (75-1-7)
11 Respiratory Failure in Infancy and Childhood; at Williamsport Hosp. (75-1-43)
14-25 Workshops in Respiratory Intensive Care; at Hahnemann, Philadelphia (75-1-21)
16 Sleep Disorders; at Allentown Hosp. (75-1-38)
16 Musculoskeletal Problems as Seen in Office Practice; at Temple, Philadelphia (75-1-15)
16 Thyroid Function Tests, Interpretations and Drug Interference; ADR Center, St., John's Hosp., Pittsburgh (75-1-137)
16 Diagnosis and Treatment of Disease of the Peripheral Circulation (Arterial & Venous) in the Office, at Shadyside Hosp., Pittsburgh (75-1-117)
16 Diagnosis and Treatment of Liver Disorders; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
16-18 Echocardiography in Its Clinical Setting; by Amer. Coll. of Cardiology, Philadelphia (75-1-290)
17 You Asked For It!; at Polyclinic Hosp., Harrisburg (75-1-124)
17 Bleeding and Clotting Time Disorders; at Hazleton St. Gen. Hosp. (75-1-47)

17-18 •	Hemiplegic Rehabilitation; at Temple, Philadelphia (75-1-148)
22-24•	Annual Conference of PAO&O; at Bedford Springs Hotel, Bedford (75-1-6)
22-24	Optimal Standards of Care in Cardiac Emergencies; by Amer. Coll. of Cardiology, Philadelphia (75-1-291)
23 •	Staufer Lecture (Radiology); at Temple, Philadelphia (75-1-188)
23	Pre- and Post-operative Evaluation and Management; at Sunbury Community Hosp. (75-1-9)
24	GI Bleeding; at Hazleton St. Gen. Hosp. (75-1-47)
24	The Physical Diagnosis of the Cardiovascular System; Good Samaritan Hosp., Pottsville (75-1-293)
24-26•	Third Annual Course on Oculo-Plastic Surgery; at Wills Eye Hosp., Philadelphia (75-1-18)
28-May 16 •	Emergency Room Medicine (Preceptor Program); at Temple, Philadelphia (75-1-146)

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1	Preoperative Evaluation and Sedation - (Anesthesiologist); at Hazleton St. Gen. Hosp. (75-1-47)
1	Management of Drug Eruption: at Pottsville Hosp. (75-1-1)
5-9	General Medicine Reviews; by Hahnemann, Philadelphia (75-1-23)
5-9 •	Advanced Diagnostic Ultrasound Training Course in Echocardiography; by Temple, Philadelphia (75-1-145)
7	Management of Benign Intractable Pain Syndromes; at Sacred Heart Hosp., Allentown (75-1-38)
7	Obesity - Facts and Fancy Concerning Causation & Treatment; at Holy Redeemer Hosp., Meadowbrook (75-1-19)
7	Management of Benign Intractable Pain; at Temple, Philadelphia (75-1-14)
8	Recent Innovations in Radiologic Diagnosis; at Hazleton St. Gen. Hosp. (75-1-47)
8-9 •	Pediatric Ophthalmology Symposium; by Temple, Philadelphia (75-1-17)
9	Evaluation of Gallbladder Disease and Current Therapy; at Williamsport Hosp. (75-1-43)
12-14 •	Recent Developments in Medical Oncology; ACP, Philadelphia (75-1-2)
13-16 •	24th Annual Pediatric Seminar; by Temple, Philadelphia (75-1-18)
14	Office Dermatology; at Temple, Philadelphia (75-1-16)
15	Immunology I; at Hazleton St. Gen. Hosp. (75-1-47)
15-16 •	Concepts and Implications of Sensory Feedback Therapy; at Temple, Philadelphia (75-1-149)
21	Allergic Problems in Childhood; at Allentown Hosp. (75-1-38)
21	Office Endocrinology; at Temple, Philadelphia (75-1-13)
21	Modern Management of Common Skin Disorders; ADR Center, St. John's Hosp., Pittsburgh (75-1-137)
21	Fluid Replacement; at Soldiers & Sailors Mem. Hosp.; Wellsboro (75-1-4)
22	Immunology II; at Hazleton St. Gen. Hosp. (75-1-47)
29	Immunology III; at Hazleton St. Gen. Hosp. (75-1-47)
29	Symposium on Pneumoconiosis with Interpretation of Pulmonary Function Testing; Good Samaritan Hosp., Pottsville (75-1-293)

JUNE

2-6 •	Diagnostic Ultrasound Training Course-Introductory; by Temple, Philadelphia (75-1-143)
4	Diagnosis and Treatment of Drug Overdose; at Easton Hosp. (75-1-10)
5	Changing Concepts in Contraceptive Techniques; at Pottsville Hosp. (75-1-1)
13	Immunology and Allergy Workshop; at Williamsport Hosp. (75-1-43)
14	Mechanisms of Diarrhea with Implications for Treatment at Sacred Heart Hosp., Allentown (75-1-38)
18	Dermatology; at Allentown Hosp. (75-1-38)
18	U.R.I. in Children; ADR Center, St. John's Hosp., Pittsburgh (75-1-137)
18	EKG (Simplified Interpretation); at Soldiers & Sailors Mem. Hosp., Wellsboro (75-1-4)

The Pennsylvania Steering Committee on Continuing Education for Physicians in Psychiatry, Benjamin Schneider, M.D., Chairman, remains interested in helping physicians find approved training opportunities. The Committee can be contacted through the office of the Pennsylvania Academy of Family Physicians, 5600 Derry Street, Harrisburg, Pennsylvania, 17111; Phone: (717) 564-5365.

Announcing . . .
H E R S
(Health Education Resource Service)

A new catalog is being published that will include the various media resources that are available in the major medical institutions in Pennsylvania. Many of these items are available for loan on request. The catalog will explain the specific provisions regarding loan and will include the name of the person to contact to complete the loan arrangements.

For your copy of the HERS Catalog, contact:

Pennsylvania Medical
Continuing Education Institute
20 Erford Road
Lemoyne, Pennsylvania 17043

Accredited Institutions

All continuing medical education programs planned by any of these institutions may be reported on an hour-for-hour basis for credit in Category I toward the AMA Physician's Recognition Award and the PMS membership requirement.

Medical Schools

Albany Medical College of Union University
Albert Einstein College of Medicine of Yeshiva University
Baylor College of Medicine
Boston University School of Medicine (Division of Psychiatry)
Bowman Grey School of Medicine of Wake Forest U.
Charles R. Drew Postgraduate Medical School - Los Angeles County/Martin Luther King, Jr. Hospital
Chicago Medical School (Department of Psychiatry)
College of Physicians and Surgeons of Columbia University
Columbia University School of Public Health and Administrative Medicine
Cook County Graduate School of Medicine
Duke University Medical School
French and Polyclinic Medical School and Health Center
Georgetown University School of Medicine
George Washington University Medical Center
*Hahnemann Medical College
Harvard Medical School
Howard University College of Medicine
Indiana University School of Medicine
*Jefferson Medical College of Philadelphia
Johns Hopkins University School of Medicine
Loma Linda University School of Medicine
Louisiana State University Medical Center School of Medicine in Shreveport
Louisiana State University School of Medicine
Mayo Clinic (Mayo Graduate School of Medicine)
Medical College of Georgia
*Medical College of Pennsylvania
Medical College of Virginia School of Medicine
Medical University of South Carolina
Meharry Medical College
Mount Sinai School of Medicine of the City University of New York - Page and William Black Postgraduate School of Medicine
New York Medical College Dept. of Psychiatry
Ohio State University College of Medicine (Center for Continuing Medical Education)
*Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center
St. Louis University School of Medicine (Department of Psychiatry)
Stanford University School of Medicine
State University of New York at Buffalo School of Medicine
State University of New York, Downstate Medical Center
*Temple U. Health Sciences Center
Tufts University School of Medicine
Tulane University School of Medicine
University of Alabama School of Medicine
University of California, Irvine-California College of Medicine
University of California, Los Angeles School of Medicine (UCLA Center for Health Sciences)

Pennsylvania Institution

University of California, San Francisco (Continuing Education in Health Sciences)
University of Chicago
University of Cincinnati College of Medicine
University of Colorado School of Medicine
University of Florida College of Medicine
University of Iowa College of Medicine
University of Kansas School of Medicine
University of Kentucky College of Medicine
University of Maryland School of Medicine
University of Miami School of Medicine
University of Michigan School of Medicine
University of Minnesota Medical School
University of Mississippi School of Medicine
University of Missouri-Columbia School of Medicine
University of Missouri-Kansas City School of Medicine (Kansas City S.W. Clinical Society)
University of Nebraska Medical Center
University of New Mexico School of Medicine and New Mexico Regional Medical Program
University of North Carolina School of Medicine
University of Oklahoma Medical Center
University of Oregon Medical School
*University of Pennsylvania School of Medicine
*University of Pittsburgh School of Medicine
University of Southern California School of Medicine
University of Tennessee College of Medicine
University of Texas Health Science Center at Houston
University of Texas Medical Branch
University of Texas Medical School at San Antonio
University of Texas S.W. Medical School at Dallas
University of Utah College of Medicine
University of Washington School of Medicine
University of Wisconsin Medical School
Vanderbilt University School of Medicine
Yale University School of Medicine

Specialty Societies

American Academy of Allergy
American Academy of Dermatology
American Academy of Facial, Plastic and Reconstructive Surgery, Inc.
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology and Otolaryngology
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Psychoanalysis
American Association for Clinical Immunology and Allergy
American Association for Thoracic Surgery
American Association of Neurological Surgeons
American College Health Association
American College of Allergists
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Psychiatrists
American College of Radiology
American College of Surgeons
American Electroencephalographic Society
American Fertility Society
American Fracture Association
American Gastroenterological Association
American Geriatrics Society
American Institute for Psychoanalysis
American Neurotology Society
American Psychiatric Association
American Psychoanalytic Association
American Rhinologic Society
American Society for Adolescent Psychiatry
American Society for Head & Neck Surgery
American Society of Abdominal Surgeons
American Society of Anesthesiologists
American Society of Clinical Hypnosis
American Society of Clinical Pathologists
American Society of Contemporary Medicine and Surgery/Society for Contemporary Ophthalmology
American Society of Cytology
Am. Soc. of Ophthalmologic & Otolaryn. Allergy
Am. Soc. of Plastic & Reconstructive Surg. Inc.
American Thoracic Society of Louisiana
American Urological Association, Inc.
Arthritis Foundation and Constituent Societies
Boston Psychoanalytic Society and Institute, Inc.
Chicago Ophthalmological Society
College of American Pathologists
Congress of Neurological Surgeons, Inc.
Eastern Orthopaedic Association
Illinois Society of Anesthesiologists
Industrial Medical Association
International Anesthesia Research Society
International College of Surgeons
New Jersey State Society of Anesthesiologists Inc.
New Orleans Academy of Ophthalmology
New York State Society of Anesthesiologists Inc.
Nuclear Medicine Institute
Oregon Academy of Ophthalmology and Otolaryngology
Pacific Coast Fertility Society, Inc.
Pacific Dermatologic Association
*Pennsylvania Academy of Dermatology
*Pennsylvania Academy of Family Physicians
*Pa. Academy of Ophthalmology and Otolaryngology
*Pennsylvania Association of Clinical Pathologists
*Pennsylvania Radiological Society
*Philadelphia Roentgen Ray Society
Puget Sound Academy of Ophthalmology
Puget Sound Academy of Otolaryngology
Radiological Society of North America, Inc.
Regional Council of Child Psychiatry
Research Study Club of Los Angeles, Inc.
Rogers Heart Foundation, Inc.
Southwestern Gynecologic Assembly
Undersea Medical Society
Washington Psychoanalytic Society
Western Orthopaedic Association
William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology
Wisconsin Society of Anesthesiologists

Voluntary Health Agencies

American Cancer Society, Inc.
American Diabetes Association, Inc.
American Heart Association, Inc.
La Leche League International
New York Trudeau Society

State Medical Associations and Societies

Academy of Medicine of New Jersey
Illinois Council on Continuing Medical Education
Kentucky Medical Association
Medical and Chirurgical Faculty—State of Maryland
Minnesota State Medical Association
New Mexico Medical Society
*Pennsylvania Medical Society
Postgraduate Medical Institute, Boston, Mass.

Hospitals

Adolf Gundersen Medical Foundation, LaCrosse, Wis.
Akron City Hospital, Akron, Ohio
Alexian Brothers Hospital, Elizabeth, N.J.
Atlantic City Hospital, Atlantic City, N.J.
Baroness Erlanger Hospital - Chattanooga, Tenn.
Beckley Appalachian Regional Hospital, Beckley, W. Va.
Bristol Memorial Hospital - Bristol, Tenn.
Bronx-Lebanon Hospital Center (Div. of Microbiology & Epidemiology - Bronx, N.Y.
Brooklyn Eye & Ear Hospital - Brooklyn, N.Y.
California Hospital Medical Center, Los Angeles, Calif.
Cedars-Sinai Medical Center, Cedars of Lebanon Hospital Division, Los Angeles, Calif.
Chapman General Hospital, Orange, Calif.
*Chestnut Hill Hospital, Philadelphia, Pa.
Children's Hospital, Denver, Colo.
Children's Hospital, Long Beach, Calif.
Children's Hospital, San Francisco, Calif.
Children's Hospital of Los Angeles (Division of Anesthesiology) Los Angeles, Calif.
Children's Hospital of Orange County, Orange, Calif.
Clarksville Memorial Hospital, Clarksville, Tenn.
Cleveland Clinic Educational Foundation, Cleveland, Ohio
Community Hospital - Los Gatos, Calif.

Pennsylvania Institution

*Conemaugh Valley Memorial Hospital, Johnstown, Pa.
Cooper Hospital (The), Camden, N.J.
*Delaware County Memorial Hospital, Drexel Hill, Pa.
Donald N. Sharp Memorial Community Hospital, San Diego, Calif.
*Eastern Pennsylvania Psychiatric Institute, Philadelphia, Pa.
Elizabeth General Hospital and Dispensary, Elizabeth, N.J.
*Elwyn Institute, Elwyn, Pa.
Esperanza Intercommunity Hospital, Yerba Linda, Calif.
Everett A. Gladman Memorial Hospital, Oakland, Calif.
FAB 3/CME, c/o American Hospital, Chicago, Ill.
Franklin Square Hospital, Baltimore, Md.
Fullerton Community Hospital, Fullerton, Calif.
*Geisinger Medical Center, Danville, Pa.
General Hospital, County of Ventura, Ventura, Calif.
Gill Memorial Hosp. Fndn. Inc. Roanoke, Va.
Good Samaritan Hospital, Phoenix, Ariz.
Good Samaritan Hospital and Medical Center, Portland, Oreg.
Greater Baltimore Medical Center, Baltimore, Md.
Greenwich Hospital, Greenwich, Conn.
*Harrisburg Hospital, Harrisburg, Pa.
*Harrisburg Polyclinic Hospital, Harrisburg, Pa.
Hospital of the Good Samaritan, Los Angeles, Calif.
*Institute of the Pennsylvania Hospital, Philadelphia, Pa.
Jackson-Madison County General Hospital, Jackson, Tenn.
*Jeanes Hospital, Philadelphia, Pa.
Johnson Memorial Hospital, Stafford Springs, Conn.
Kaiser Foundation Hospital - Bellflower, Calif.
Kaiser Foundation Hospital - Fontana, Calif.
Kaiser Foundation Hospital, Harbor City, Calif.
Kaiser Foundation Hospital, Hayward, Calif.
Kaiser Foundation Hospital, Los Angeles, Calif.
Kaiser Foundation Hospital, Oakland, Calif.
Kaiser Foundation Hospital - Panorama City, Calif.
Kaiser Foundation Hospital, Redwood City, Calif.
Kaiser Foundation Hospital, Richmond, Calif.
Kaiser Foundation Hospital, Sacramento, Calif.
Kaiser Foundation Hospital, San Francisco, Calif.
Kaiser Foundation Hospital, Santa Clara, Calif.
Kaiser Foundation Hospital, Vallejo, Calif.
Kaiser Foundation Hospital, Walnut Creek, Calif.
Lahey Clinic Foundation, Boston, Mass.
Lawrence and Memorial Hospitals, New London, Conn.
*Lehigh Valley Area Health Education Center, Allentown, Pa.
Lenox Hill Hospital, New York, N.Y.
Long Beach Community Hospital, Long Beach, Calif.
Long Island Jewish-Hillside Medical Center/Queens Hospital Center Clinical Campus, New Hyde Park, N.Y.
Lovelace Foundation for Medical Education and Research, Albuquerque, N. Mex.
Manchester Memorial Hospital, Manchester, Conn.
Maricopa County General Hospital - Phoenix, Ariz.
Martha Washington Hospital, Chicago, Ill.
Memorial Hospital, South Bend, Ind.
Memorial Hospital for Cancer & Allied Diseases, N.Y., N.Y.
Memorial Hospital Medical Center of Long Beach, Long Beach, Calif.
Memorial Hospital of DuPage County, Elmhurst, Ill.
Menorah Medical Center, Kansas City, Missouri
Mercy Hospital, Baltimore, Md.
*Mercy Hospital, Pittsburgh, Pa.
Mercy Hospital & Medical Center, San Diego, Calif.
Midway Hospital, Los Angeles, Calif.
Mills Memorial Hospital, San Mateo, Calif.
Monmouth Medical Center, Long Branch, N.J.
Morristown Memorial Hospital, Morristown, N.J.
Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.
Mt. Sinai Hospital of Greater Miami, Miami Beach, Fla.
Mt. Zion Hospital and Medical Center, San Francisco, Calif.
Newark Beth Israel Medical Center, Newark, N.J.
*Norristown State Hospital, Norristown, Pa.
Oak Park Hospital, Oak Park, Ill.
O'Connor Hospital, San Jose, Calif.
Orthopaedic Hospital, Los Angeles, Calif.
Pacific Hospital of Long Beach, Long Beach, Calif.
*Paoli Memorial Hospital, Paoli, Pa.
*Phoenixville Hospital, Phoenixville, Pa.
Piedmont Hospital, Atlanta, Georgia
Placentia-Linda Hospital, Placentia, Calif.
Postgraduate Institute of the New York Eye and Ear Infirmary, New York, N.Y.
Presbyterian Hospital of Pacific Medical Center, San Francisco, Calif.
Presbyterian Hospital - Albuquerque, N.M.
Providence Hospital, Washington, D.C.
*Reading Hospital, Reading, Pa.
*Robert Packer Hospital, Sayre, Pa.
Roosevelt Hospital, Metuchen, N.J.
Roseville Community Hospital, Roseville, Calif.
St. Barnabas Medical Center, Livingston, N.J.
St. Elizabeth Hospital, Elizabeth, N.J.
*St. Francis General Hospital, Pittsburgh, Pa.
St. Francis Hospital, Trenton, N.J.
St. Joseph Hospital - Albuquerque, N.M.
St. Joseph Hospital, Baltimore, Md.
St. Joseph Hospital, Orange, Calif.
St. Joseph Hospital, South Bend, Ind.
St. Joseph Hospital & Medical Center, Phoenix, Az.
St. Jude Hospital, Fullerton, Calif.
St. Luke's Hospital & Medical Center, Phoenix, Ariz.
*St. Margaret Memorial Hospital, Pittsburgh, Pa.
St. Mary's Long Beach Hosp., Long Beach, Calif.
St. Mary's Hospital, San Francisco, Calif.
St. Michael's Medical Center, Newark, N.J.
San Joaquin General Hospital, Stockton, Calif.
Santa Monica Hospital Medical Center, Santa Monica, Calif.
Scott and White Memorial Hospital, Scott Sherwood & Brindley Foundation, Temple, Tex.
Scripps Clinic & Research Fndn., Lajolla, Calif.
Sequoia Hospital District, Redwood City, Calif.
Sinai Hospital of Baltimore, Inc., Baltimore, Md.
Sonoma Valley District Hospital, Sonoma, Calif.
South Baltimore General Hospital, Baltimore, Md.
South Coast Community Hospital, South Laguna, Calif.
Spring Grove State Hospital, Baltimore, Md.
United Hospitals of Newark, Newark, N.J.
Valley Presbyterian Hospital, Van Nuys, Calif.
Variety Children's Hospital, Miami, Florida
Veterans Administration Center, Prescott, Ariz.
Veterans Admin. Hosp., Perry Point, Md.
*Veterans Adm. Hosp., Coatesville, Pa.
*Veterans Admin. Hosp., Lebanon, Pa.
Veterans Home & Hospital, Rocky Hill, Conn.
Virginia Mason Medical Center, Seattle, Wash.
*Warren State Hospital, Warren, Pa.
*Washington Hospital, Washington, Pa.
Washington Hospital Center, Washington, D.C.
Watson Clinic, Lakeland, Fla.
*Western Pennsylvania Hospital, Pittsburgh, Pa.
West Valley Community Hospital Foundation, Encino, Calif.
William S. Hall Psychiatric Institute, Columbia, S.C.
Wilmer Ophthalmological Institute, The Johns Hopkins Hospital, Baltimore, Md.
Woodland Clinic Medical Group, Woodland, Calif.
*York Hospital, York, Pa.

Others

American Medical Association, Council on Scientific Assembly, Chicago, Ill.
AMA Dept. of Mental Health & Council on Mental Health, Chicago, Ill.
Armed Forces Institute of Pathology, Washington, D.C.
Association for Hospital Medical Education, Arlington, Va.
Brigham Young University, Provo, Utah
Bureau of Medicine & Surgery, Navy Dept., Washington, D.C.
Center for Disease Control, Atlanta, Ga.
Chicago Medical Society, Chicago, Ill.
Colby College, Waterville, Maine
Commission on Professional and Hospital Activities, Ann Arbor, Mich.
Civil Aeromedical Institute, Office of Aviation Medicine, FAA, Oklahoma City, Okla.
Dallas Southern Clinical Society, Dallas, Tex.
Department of the Air Force, Division of Medical Education, Washington, D.C.
Department of the Army, Office of the Surgeon General, Washington, D.C.
International Academy of Pathology, Augusta, Ga.
Interstate Postgraduate Medical Association of North America, Madison, Wis.
Joint Commission on Accreditation of Hospitals, Chicago, Ill.
Knoxville Academy of Medicine, Knoxville, Tenn.
Margaret Sanger Research Bureau, Inc., N.Y., N.Y.
Menninger Foundation, Div. Industrial Mental Health, Topeka, Kan.
Montelores Medical Society, Cortez, Colo.
National Association of Private Psychiatric Hospitals, Leonia, N.J.
Northwestern Ohio Institute for Continuing Medical Education, Toledo, Ohio
Oak Ridge Associated Universities - Special Training Division, Oak Ridge, Tenn.
Omaha Mid-West Clinical Society, Omaha, Nebr.
Phil Thorek Postgraduate Courses, Chicago, Ill.
Postgraduate Center for Mental Health, New York, N.Y.
Rudolph Ellender Medical Foundation, Inc., Houma, La.
Southern Medical Assn., Birmingham, Ala.

**Pennsylvania Institution*

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Classifying is done by sponsor. Activities shown under any given subject are generally of a quality that would be helpful to specialists in that field. Registration may be open to others.

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Williamsport; Williamsport Hosp. (75-1-43)
York; York Hosp. (75-1-44)

GENETICS
Norristown (74-1-73)
Philadelphia; EPPI (74-1-33)

KEY:
(75-1-XX) Numbers in parentheses are code numbers which refer to specific items in the "Announcement" section of this supplement. See: town, institution, and code numbered item for complete details.

GERIATRICS
Harrisburg; PMS (74-1-78)

HEMATOLOGY
Philadelphia; Jeanes (75-1-89)

INTERNAL MEDICINE
Abington (75-1-5)
Bethlehem; St. Luke's Hosp. (75-1-49)
Danville (75-1-101)
Harrisburg; Harrisburg Hosp. (75-1-125)
Philadelphia; A C P (74-1-2, 3 and 6)
Philadelphia; A C P (75-1-2)
Philadelphia; Albert Einstein Med. Center - Northern Div. (75-1-252 and 253)
Philadelphia; EPPI (74-1-33)
Philadelphia; EPPI (75-1-84)
Philadelphia; Hahnemann (75-1-22 and 240)
Philadelphia; Jeanes (74-1-34)
Philadelphia; MCP (75-1-211)
Philadelphia; Temple (75-1-153, 154, 156)
Pittsburgh; ACP (74-1-20)
Pittsburgh; Mercy (75-1-73)
Pittsburgh; Pitt (74-1-47 and 51)
Pittsburgh, St. Margaret (75-1-56, 65, 66 and 68 to 70)
Sayre (75-1-271)

MICROBIOLOGY and IMMUNOLOGY
Philadelphia; Temple (75-1-161)

NEUROLOGY
Coatesville; Coatesville VA (74-1-21)
Danville (75-1-105)
Hershey (75-1-28)
Norristown (74-1-71)
Norristown (75-1-206)
Philadelphia; Albert Einstein Med. Center - Northern Div. (75-1-254, 255 and 267)
Philadelphia; Hahnemann (75-1-229 to 231)
Philadelphia; MCP (75-1-211)
Philadelphia; Philadelphia Gen. Hosp. (75-1-279)
Philadelphia; Temple (75-1-181 to 183)
Philadelphia; U. of Pa. (75-1-276)
Pittsburgh, St. Margaret (75-1-60)

OBSTETRICS and GYNECOLOGY
Bethlehem; St. Luke's Hosp. (75-1-50)
Danville (75-1-93 and 94)
Hershey (75-1-29)
Philadelphia; Albert Einstein Med. Center - Northern Div. (75-1-256 and 257)
Philadelphia; MCP (75-1-211)
Philadelphia; Temple (74-1-67)
Philadelphia; Temple (75-1-169 and 170)
Pittsburgh; Pitt (74-1-56)
Pittsburgh; St. Francis (75-1-140)
Pittsburgh; St. Margaret (75-1-61)

ONCOLOGY
Danville (75-1-106 and 107)
Philadelphia; ACP (75-1-2)
Philadelphia; Jeanes (74-1-35 and 36)
Philadelphia; Philadelphia Gen. Hosp. (75-1-286)
Philadelphia; Temple (75-1-175, 176, 245)
Sayre (75-1-269)

OPHTHALMOLOGY
Bedford; PAO&O (75-1-6)
Philadelphia; Temple (75-1-17 and 150)
Philadelphia; Wills Eye Hosp. (75-1-7 and 8)
Reading; PAO&O (75-1-54)

ORTHOPEDIC SURGERY
Harrisburg (74-1-80)
Philadelphia; Hahnemann (75-1-20)
Philadelphia; Temple (75-1-152 and 193 to 198)
Pittsburgh; St. Margaret (75-1-67 and 72)

OTOLARYNGOLOGY
Bedford; PAO&O (75-1-6)
Philadelphia; Temple (75-1-46)
Pittsburgh; Mercy (75-1-3 and 76)
Pittsburgh; PAO&O (75-1-55)
Pittsburgh; Pitt (74-1-55 and 57)
Pittsburgh; Pitt (75-1-134)
Reading; PAO&O (75-1-54)

PATHOLOGY
Danville (74-1-4)
Danville (75-1-100)
Hershey (75-1-30)
Philadelphia; Albert Einstein Med. Center - Northern Div. (75-1-258 and 259)
Philadelphia; MCP (75-1-211)
Philadelphia; Philadelphia Gen. Hosp. (75-1-285)
Philadelphia; U. of Pa. (75-1-288 and 289)

PEDIATRICS
Danville (75-1-96 and 104)
Hershey (75-1-31 to 33)
Philadelphia; Albert Einstein Med. Center - Northern Div. (75-1-260)
Philadelphia; MCP (75-1-211)
Philadelphia; Temple (75-1-18 and 171 to 173)
Philadelphia; EPPI (75-1-82)
Pittsburgh; St. Margaret (75-1-62)

PHARMACOLOGY
Philadelphia; EPPI (75-1-84)

PHYSICAL MEDICINE and REHABILITATION
Danville (75-1-99)
Harrisburg (74-1-81)
Philadelphia; Philadelphia Gen. Hosp. (75-1-280 to 282)
Philadelphia; Temple (75-1-148, 149, 178 to 180)
Pittsburgh; St. Francis (75-1-141)

PSYCHIATRY
Bethlehem; St. Luke's Hosp. (75-1-51)
Coatesville; Coatesville VA (74-1-1)
Easton (75-1-217)
Harrisburg (74-1-82)
Haverford (74-1-8)
Hershey (75-1-34)
Lancaster; Lancaster Gen. Hosp. (75-1-200)
Norristown (74-1-70 and 74)
Norristown (75-1-205, 207 to 209)
Philadelphia; EPPI (74-1-33)
Philadelphia; EPPI (75-1-82 to 85)
Philadelphia; Hahnemann (74-1-76)
Philadelphia; Hahnemann (75-1-212 to 216)
Philadelphia; Institute (74-1-29 to 32, 93 and 94)
Philadelphia; Institute (75-1-78 to 81, and 292)
Philadelphia; MCP (75-1-211)
Philadelphia; Temple (75-1-147 and 177)
Philadelphia; Philadelphia Gen. Hosp. (75-1-283 and 287)
Pittsburgh; St. Margaret (75-1-63)
Pittsburgh; Staunton Clinic (74-1-88)

RADIOLOGY
Hershey (75-1-35)
Philadelphia; Albert Einstein Med. Center - Northern Div. (74-1-84)
Philadelphia; Albert Einstein Med. Center - Northern Div. (75-1-261 to 263)
Philadelphia; Jeanes (75-1-90)
Philadelphia; MCP (75-1-211)
Philadelphia; Temple (75-1-143 to 145 and 184 to 188)
Pittsburgh; St. Margaret (75-1-64)

SURGERY
Bethlehem; Eastern Pa. Chapt., ACS (74-1-22)
Harrisburg (74-1-89 and 90)
Harrisburg; Harrisburg Hosp. (75-1-126)
Hershey (75-1-36)
Philadelphia; Albert Einstein Med. Center - Northern Div. (75-1-264 to 266)
Philadelphia; Colon & Rectal Surgs. (74-1-65)
Philadelphia; MCP (75-1-211)
Philadelphia; Philadelphia Gen. Hosp. (75-1-284)
Philadelphia; Temple (75-1-166 to 168)
Philadelphia; U. of Pa. (75-1-277)
Pittsburgh; Pitt (74-1-58 and 59)
Pittsburgh; Pitt (75-1-131)
Pittsburgh; St. Francis (75-1-142)
Pittsburgh; St. Margaret (75-1-71)
Sayre (75-1-268)
Williamsport; Williamsport Hosp. (74-1-23)

UROLOGY
Harrisburg (74-1-79)
Philadelphia; Temple (75-1-189)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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for relief of excessive anxiety

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Please see reverse side for summary of product information.

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OF MEDICINE

A. Reynolds Crane, M.D., President
Pennsylvania Medical Society

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pennsylvania medicine

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medigram October 1974

ABORTION CONTROL ACT EFFECTIVE OCTOBER 10

Overriding the veto of Governor Milton J. Shapp the Pennsylvania Legislature has enacted into law Senate Bill 1319, the Abortion Control Act, now Act 209 of 1974. Although suit has been filed in federal court to test its constitutionality, and a three-judge panel is to hold hearings October 1, the Department of Health has announced that all health care facilities, including hospitals, clinics, and physician's offices, are required to obtain department approval as facilities where pregnancy termination surgery may be performed. Gordon W. Allan, M.D., director of maternal and child health for the department, emphasized that the act specifically includes physicians' offices, which were excluded in rules for ambulatory gynecological surgery promulgated by the department prior to passage of Act 209 (see page 13 of this issue for details of those rules). Exclusion of physician's offices from these rules is now reversed for abortions, since every facility seeking approval must certify that it will adhere satisfactorily to the appropriate sections of the rules. Some 7,500 physicians, doctors of medicine and osteopathy whose practice or specialty would indicate they might be performing pregnancy termination surgery in the office, are receiving letters of notification from the Department of Health. Those now performing abortions in their offices or expecting to do so must register with the department. Requests should be sent to: Pennsylvania Department of Health, Bureau of Children's Preventive and Restorative Services, Maternal Health Section, P.O. Box 90, Harrisburg, PA 17120. The Abortion Control Act also calls for keeping precise records on Department of Health forms, notification of the department of the number of abortions performed, written informed consent of the mother, written consent of the spouse if he is available, and consent of one parent or person in loco parentis if the mother is under age 18. No abortion may be performed by anyone other than a physician or in a facility not approved by the Department of Health. No abortion may be performed during the stage of pregnancy subsequent to viability except to preserve the life or health of the mother. Violation of the law is punishable by fines and/or imprisonment. Physicians performing pregnancy termination surgery after October 10 are advised to consult their attorneys to be certain that informed consent patient discussions and records meet the requirements of Act 209.

ACUPUNCTURE POLICY REITERATED

At its September meeting, the State Board of Medical Education and Licensure reiterated its previous policy statement on acupuncture, and announced its intention to publish rules and regulation governing its use. John W. Robertson, M.D., chairman of the state board, requested republication of the policy position as follows: "The State Board of Medical Education and Licensure, Commonwealth of Pennsylvania, is of the opinion that under the present Medical Practice Act, acupuncture is considered the practice of medicine. In Pennsylvania this procedure has not been researched nor proven beneficial. It is the Board's opinion that patients who have been properly examined, diagnosed, and considered for acupuncture therapy could receive same after referral by a physician to a research setting in a medical school under the guidance of a duly licensed and registered physician in this Commonwealth. A periodic report from the medical school should be presented to this Board at six-month intervals."

ARGONAUT RATE INCREASE REQUEST APPROVED A rate increase request filed by Argonaut Insurance Co., underwriter for the Society-sponsored professional liability insurance program, has been approved by the Pennsylvania Department of Insurance. Prior study and approval of the request had been given by the Society's Commission on Professional Liability Insurance and the Board of Trustees. These groups reviewed the company's loss experience during the three-year history of the program and the company's efforts in the area of malpractice loss prevention through its Medical Alert Communications Program and loss prevention seminars. This first premium increase requested since the inception of the program will provide a 50 percent increase in income from premiums. Earlier in 1974 the two other major malpractice insurance underwriters in Pennsylvania received approval of substantial rate increase requests. The new rates are effective October 1 for some 3,500 Society members who can expect the following percentage of increase in premiums based on territory and class:

Class	Territory One Philadelphia Area	Territory Two Rest of State
1	35 percent	25 percent
2	35 percent	25 percent
3	25 percent	25 percent
4	58 percent	50 percent
5	58 percent	50 percent

DATE SET FOR BLUE SHIELD HEARINGS Insurance Commissioner William J. Sheppard has announced public hearings on the Blue Shield rate increase request for 10:00 a.m. October 15 at the Executive House, Harrisburg. Those interested in attending or presenting testimony should contact Paul Henning, Bureau of Regulation of Rates and Policies, 402 Finance Bldg., Harrisburg. See page 11 of this issue for details.

NOVEMBER MEMBERSHIP RECRUITMENT MONTH The Council on Public Service will launch a membership recruitment campaign in November, Robert N. Moyers, M.D., chairman has announced. Details will appear in the November issue.

PITTSBURGH SURGEON ON AMPAC BOARD Michael P. Levis, M.D., has been elected to the Board of Directors of the American Medical Political Action Committee. Dr. Levis is a sustaining member of the Pennsylvania Medical Political Action Committee, a member of the Society's Council on Governmental Relations, and president elect of the Allegheny County Medical Society.

BIENNIAL PHYSICIAN REGISTRATION DUE The State Board of Medical Education and Licensure will mail in November registration forms to all physicians licensed to practice in Pennsylvania. The registration and fee must be returned by December 31. If you do not receive your notice by mid-December, it may be that the state board does not have your correct mailing address. In this case you should contact the state board immediately. Included in the mailing this year will be a Health Department data base form which should be returned with your registration.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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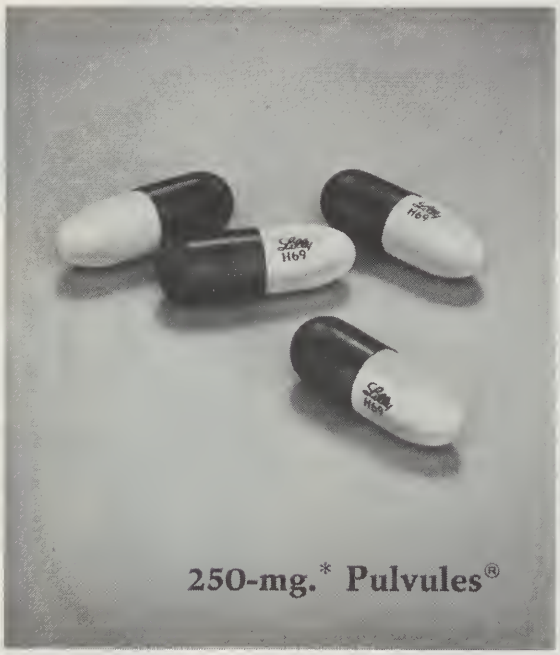

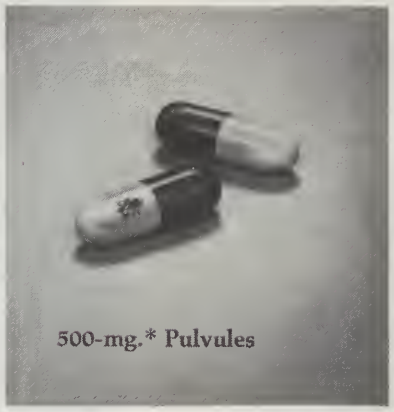

*Equivalent to cephalexin.

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A. Reynolds Crane, M.D., formally installed October 11

Society President A. Reynolds Crane, M.D., will be formally installed at the State Dinner scheduled for October 11 during the Annual Session of the House of Delegates at the William Penn Hotel in Pittsburgh. He has served as Society president since leukemia claimed the life of Ralph C. Wilde, his predecessor, and prior to that served as president elect and vice president. From 1963 to 1972 he served the Society as trustee and councilor from the First District.

Dr. Crane, 66, was until June 30 director of the Ayer Clinical Laboratory at Pennsylvania Hospital and pathologist to the Benjamin Franklin Clinic there. He remains as consultant to the laboratory and will continue as professor of pathology at the University of Pennsylvania School of Medicine.

For A. Reynolds Crane, studying medicine was a decision made early in life and he attributes it to the example set by his family's physician, Palmer Townsend, M.D. Dr. Crane recalled, "He was a great man, full of warmth and compassion. When I entered medical school, he gave me the microscope he had used when a medical student forty years before. He followed my course with the pride of a father."

He was graduated from Hamilton College, Geneva, N. Y., and received his degree in medicine from Cornell University. From 1935 to 1939 he was an assistant at the Mallory Institute of Pathology at Boston City Hospital. As he was beginning the fifth year of his pathology residency, Dr. Crane discovered that he had tuberculosis, and he spent the next two years in the State Sanitorium at Rutland, Mass.

He recovered, he said, "by the grace of God and the guidance of a great physician, Paul Default, who was also a refugee from 'the little red bug'."

Dr. Crane's accomplished career in the field of pathology has been accompanied by a number of honors and appointments. In 1946 he became director of the Ayer Laboratory. He was assistant professor of pathology at Jefferson Medical College from 1947 to 1957, when he became professor at the University of Pennsylvania School of Medicine. Future plans include research as a senior staff member at the Institute for Cancer Research in Fox Chase. A founding fellow of the College of American Pathologists, he has enjoyed membership in and served as an officer of a number of professional societies. He is a fellow of the American College of Physicians and the American Society of Clinical Pathologists. He served as president of the Philadelphia Pathological Society, the Pennsylvania Association of Clinical Pathologists, and the Philadelphia County Medical Society. His contributions in civic affairs include assisting in the development of the medical examiner's system in Philadelphia and the impartial medical testimony panel for the Federal Court.

In 1969 the U.S. Army awarded him its outstanding civilian service award and this year the Philadelphia Pathological Society presented the Gerhard Medal to him. He is a member of the Blue Shield Board of Directors and its Executive Committee, and served on the Board of Directors of Blue Cross of Greater Philadelphia for ten years. He and his wife, Harriett, reside in Radnor.

County societies receive share of AMA dues rebate

Fifty-eight county medical societies in Pennsylvania have received their share of a rebate received from the AMA by the State Society for remitting AMA dues quickly.

In the new program, a departure from AMA past practice of returning 1 percent of AMA dues to state societies as a bonus for collecting the dues, AMA pays one-half of 1 percent above the prime interest rate on all dues received before April 1.

As in the past, the Board of Trustees voted to share the rebate with county medical societies, but on a new formula in keeping with the new, two-year experimental rebate program initiated by the AMA. Total rebate was $11,920.74. The county society share, $5,960.37, was apportioned as follows: (a) 50 percent of the county share to county societies for AMA dues from active members remitted by January 31; (b) 40 percent to county societies reporting such dues between February 1-28; and (c) 10 percent for dues reported for the period March 1-15.

The amount of rebate under this plan in 1975 will depend on a statewide effort. The more dues reported to the AMA during the first three months, the larger the rebate to be distributed.

'Keep good records' first rule in subjective informed consent

DANIEL J. MENNITI, Ph.D., J.D.
Harrisburg

Several years ago I had the opportunity of talking with a physician immediately after he was successful in defending against a negligence charge brought about by a prescription for chloromycetin. When I asked him what he learned from his experience, his answer was one that I shall never forget: "Keep good records." The situation involved a patient of this physician who was a physician herself and who had renewed prescriptions for chloromycetin after the original experimental prescription had run out. The result was death from aplastic anemia. The point of all this, however, is simply to emphasize what every physician should know, namely, that if a problem arises concerning informed consent, especially in the Commonwealth of Pennsylvania, a major help is a set of good records.

It is, of course, not news to physicians that Pennsylvania requires of physicians more than is required in some of her sister states in the matter of informed consent. The consent necessary for medical and surgical procedures has its basis in the fact that the intentional touching of another's person without permission, absent an emergency, is a legal wrong, that is, a battery. Expressed or implied authorization is necessary for all medical and surgical procedures; the obvious corollary of this is that an individual has the right to refuse to authorize the performance of a procedure upon him. Note that the question of liability for performing a medical or surgical procedure without the consent of the patient is separate and distinct from the question of negligence in performing the procedure. Liability may be imposed because there was no consent to the touching; in theory it does not matter whether the procedure was performed properly or even improved the patient's health.

As was stated, the Pennsylvania test concerning informed consent is more stringent than that of some of her sister states. To put it another way, some states require an "objective test" of informed consent. This requires that a physician give as much information concerning a procedure as is ordinarily given by other physicians in his community. This test involves the measuring of a physician's disclosure to his patient against the standard for disclosure adhered to by physicians in his locality.

The other test used in Pennsylvania is the so-called "subjective test." Informed consent under this concept imposes a three-fold duty on a physician:

1. The physician must disclose all information about material risks, even though they may be collateral;

2. He cannot proceed unless the patient consents to the material risks involved. [*Cooper v. Roberts,* 220 Pa. Super, 260, 268 (1971), thus explains what the material risks are: "The physician is bound to disclose only those risks which a reasonable man would consider material to his decision whether or not to undergo treatment."]

3. The physician must inform the patient of alternatives or alternate procedures which might be utilized in his case.

The question as to what informed subjective consent requires is well exemplified by the classic Pennsylvania case of *Cooper v. Roberts.* In this case Irene Cooper agreed to undergo a gastroscopic examination by use of a fiberscope. The nature of the examination was explained to her; she was not informed, however, of the collateral risk of perforation. The reason was, simply, that the incidence of perforation with the semi rigid scope was approximately 1 in 2,500 or .04 percent. Shortly after the examination, emergency surgery had to be performed to seal a perforation in her stomach; there was no dispute that the cause of the perforation was the gastroscopic examination. Irene Cooper sued on the grounds that the physicians "had failed to apprise her of the collateral risks involved in the examination and the available medical alternatives." (*Id.* at 648-649.) The trial judge had charged the jury in the court of the first instance that the standard against which the conduct of the physician defendant had to be weighed was the amount of disclosure which would be made by "a reasonable practitioner in the medical community." (*Id.* at 649.) This is the so-called objective test mentioned earlier. Irene Cooper lost her case and appealed. The appeals court reversed the decision on the ground that:

> In Pennsylvania a consent is "informed" only if the patient knows what is apt to happen to him and the possible adverse results and dangers of the operation. The logical inference from this formulation may be that it is not the prerogative of the physician to keep secret and screen out any of the possible complications of surgery. (*Id.* at 650.)

The author is associated with the law firm of Pepper, Hamilton, and Scheetz, which provides legal counsel to the State Society.

The Court in the *Cooper* case mirrored the previous decision of the Pennsylvania Supreme Court of *Gray v. Grunnagle,* 423 Pa. 144 (1966). This decision, like its progeny, *Cooper,* was made not on the basis of negligence of the physician but rather on the basis of the fiduciary relationship between patient and physician. The court viewed "consent to medical treatment as an area basically governed by contractual concepts... Consent for the operation or treatment arises from the contract and is given only in connection with what the parties understood was to be done." (*Id.* at 156-57.)

When it comes to the question of written consent forms, it should be pointed out that the *Gray* Court held that no consent, whether oral or written, is effective unless it is given with a true understanding of the surgery, the seriousness of it, the parts of the body to be affected, the purposes for such surgery and the possible results. (*Id.* at 166.) The *Gray* court analogized the consent form to a contract between a patient and a physician based on a mutual understanding of all the relevant facts constituting a meeting of the minds as to the nature of the undertaking and the possible outcomes. This is important to consider when a physician relies upon printed forms for consent because the signed form is no defense if the patient does not understand the exact nature of the procedures to be performed upon him.

What are the possible defenses of a physician who has been sued on the grounds of a lack of informed consent? The best defense, of course, is a set of records showing that all material risks were explained to the patient. Another possible defense is that the physician can testify or can introduce testimony that a possible unexplained risk was minor and did not have to be presented to the patient. Another is that the physician was not or should not have been aware of the risk involved. This would be true especially if the patient consents to an experimental procedure.

Another remotely possible defense is that the physician might have believed that the overall well being of the patient required him to conceal some material risks. For example, in the case of a unduly apprehensive patient, if a physician determined that his patient would refuse surgery, even though it is absolutely necessary, this might be construed as an excusing reason for the physician not to present all of the possible alternatives and/or risks to the patient. In the latter situation, however, the physician is treading on dangerous ground.

This all gets us back to the problem of records. A physician should expend every possible effort to see to it that his records conform with the requirements dictated by the concept of informed consent as required in Pennsylvania. It seems to be an easy matter for a physician in draining an abscess to dictate something like the following:

> I informed Mrs. Smith today of the material risks involved in her I and D, namely, the possibility that the procedure would leave a scar or cause some disfigurement; the dangers of spread of infection, of excessive bleeding, or reaction to the antibiotics or anesthesia; the possibility that the antibiotics might not be successful.
>
> I also told her of the alternate procedures that might be available, namely, treatment by the use of antibiotics alone or allowing the cyst to come to a head and rupture by itself.
>
> Mrs. Smith understood all of this.

There is still one question that remains and that is whether a physician is without responsibility when a patient disclaims hearing about all the alternatives and risks involved in the contemplated procedure. For example, suppose Mrs. Smith comes to the office and, as Dr. Jones begins to tell her of all the material risks involved in her surgery, she says that she does not want to hear them. I believe that, in this situation, a physician should make a notation on his record, and he should have the refusal to hear the material risks involved witnessed by his secretary or nurse. All of the latter, of course, should be reduced to writing so that, in the event of a problem, the physician's records are available for defense purposes. No Pennsylvania case based on such a defense has been found so it is merely speculative to say that, in the event of a suit, the defense would be adequate.

There are no exact formulas or codes for precluding all the eventual problems stemming from the Pennsylvania requirements for informed consent. No formula or code, whatever its precision, will be effective unless the physician is deeply convinced of the dignity of the human person and has profound respect for freedom of consent. There is a vast difference between obtaining consent by overwhelming suggestion through the use of cleverly chosen words and information, and obtaining consent through completely objective information presented in such a way as to invite the full exercise of reason, judgment and freedom. Freedom of consent is necessarily related to the physician's own beliefs in the dignity of each individual patient. No legal code, no treatise on cases, no judicial decision can ever be a substitute for sympathy, understanding, and tactful teaching by the physician in his dealings with his patients.

State Society accredits four Category One sources

The Commission on Accreditation of the Pennsylvania Medical Society has authorized Category One credit for continuing education programs to a Philadelphia hospital and three specialty groups as a result of survey visit reports evaluated at its September meeting.

Frankford Hospital in Philadelphia was given authority to grant Category One credit toward the AMA Physician's Recognition Award and the PMS membership requirement for a period of two years. The Pennsylvania Allergy Association was granted similar authority. The Pennsylvania Society of Anesthesiologists and the Pennsylvania Society of Colon and Rectal Surgery were granted accreditation for four years.

See the September Supplement in PENNSYLVANIA MEDICINE for a complete listing of institutions granting Category One credit.

Criminality subject of MCP symposium

A symposium on the psychodynamic implications of the various studies in criminality will be presented by the department of psychiatry of the Medical College of Pennsylvania on November 10, 1974. Leo Madow, M.D., professor and chairman of the department, will introduce the session.

In addition to an expert on sociology and one on behavioral science, speakers will include the following professors of psychiatry: Shervert H. Frazier, M.D., Harvard Medical School; Seymour L. Halleck, M.D., University of North Carolina School of Medicine; and Andrew S. Watson, M.D., University of Michigan.

The fee is $25, and continuing education credit in Category One on an hour-for-hour basis is approved for the AMA Physician's Recognition Award and the PMS membership requirement. For further information, contact: Department of Psychiatry, Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia 19129.

Child care manuals published by HEW

Two manuals on the planning and implementation of early and periodic screening, diagnosis, and treatment for medicaid-eligible children have been issued by the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare, Caspar W. Weinberger, HEW secretary, has announced.

A "Guide to Screening" and a "Guide to Dental Care" have been issued in cooperation with the American Academy of Pediatrics, the American Society of Dentistry for Children, and the American Academy of Pedodontics. Copies may be obtained by writing the Medical Services Administration, Room 4524, Switzer Bldg., 330 C. St., S. W., Washington, D. C., 20201.

These manuals constitute the first in a series of pamphlets being prepared by the American Academy of Pediatrics on diagnosis and treatment; the American Ortho-psychiatric Association on developmental assessment and treatment; and the Health Facilities Foundation on training for allied health personnel. The American Medical Association's Committee on Health Care for the Poor is preparing a publication on professional provider participation at national, state, and local levels.

The publications are designed to acquaint public officials, physicians, and their assistants with federal regulations in the screening and treatment of 13 million medicaid-eligible children.

SOME 150 physicians, coaches, trainers, and athletic directors gathered at the second Sports Medicine Seminar held just prior to the opening of school under the sponsorship of the Lackawanna County Medical Society at the Scranton Campus of the Pennsylvania State University. Charles J. Bannon, M.D., Scranton, shown above left, served as chairman and moderator. Paul S. Butler, chief trainer at Temple University, is shown above at the microphone, Others on the panel seated in the first row, left to right, are Eli Stavisky, D.D.S., Scranton oral surgeon; Walter E. Seigle, M.D., Scranton anesthesiologist; Joseph S. Torg, M.D., chief of orthopedic surgery, Temple University School of Medicine; and Eugene K. Weiss, M.D., Scranton neurological surgeon.

Blue Shield files for $35.8 million rate increase

Pennsulvania Blue Shield is seeking approval for a $35.8 million rate increase from the Pennsylvania Insurance Department. This entails an average increase to subscribers of 31.5 percent. The increase would allow $1.3 million in additional benefits.

Plan A subscribers would pay an additional 72 cents per month; Plan B, 63 cents; Prevailing Fee, $2.63; and 65-Special subscribers, $1.34. Group subscribers whose rates are based on actual group claims experience would not be affected.

If the increase is granted, the company could expect to break even by the end of 1976, Robert E. Rinehimer, Pennsylvania Blue Shield president, said. He cited the inflationary climate, additional benefits without proportionate rate increases, and the increasing use of the service as reasons Blue Shield has been forced to take more than $45 million from its reserves in the past four-and-a-half years.

The firm lost $12.9 million in 1973 and $8 million in the first six months of this year despite an August 1973 rate increase, according to company spokesmen.

COUNTY SOCIETY OFFICERS from the Second Councilor District met September 7 at the Hilton Inn Northeast to discuss legislative issues, Professional Standards Review Organizations, and Blue Shield's Plan C proposal. Leroy A. Gehris, M.D., of Reading, trustee and councilor for the Second District, chaired the meeting. Representatives of the State Society are seated with him in the top photograph. They are, left to right, Robert H. Craig, Jr., director of governmental relations; John F. Rineman, executive vice president; Dr. Gehris; Ronald M. Bachman, acting director of economic affairs; and William F. S. Orner, Jr., coordinator of field services for the Pennsylvania Medical Care Foundation.

'Americans love hogwash'

Noted Mayo physician warns on nutrition myths

"Americans love hogwash," according to a physician who has completed an evaluation of unscientific nutrition information disseminated in popular books, newspapers, magazines, and on radio and television.

Edward Rynearson, M.D., emeritus professor of medicine, Mayo Clinic, gives his views in a special supplement of the current issue of *Nutrition Reviews*, a journal published by the Nutrition Foundation.

The author's interest in the problem came about literally by accident. While recovering from a fractured back during a long hospital stay, Dr. Rynearson began to help fill time by watching TV talk shows.

"It seemed to me that nearly every time I turned the set on there would be some so-called expert pushing a new book or expounding on some crackpot theory," says Dr. Rynearson.

The author, who has spent nearly half a century as a medical practitioner, researcher, and teacher, then began a three-year examination of the information that was being given out. He took notes of what was on the air and studied the articles and books.

In the article Dr. Rynearson deals with many areas of nutrition misinformation, but he focuses much of his attention on the theories put forward in popular books written for laymen by authors such as the late Adelle Davis and Carlton Fredericks.

Dr. Rynearson cites a number of qualified scientists who evaluated many of the claims made by Mrs. Davis in her books. As an example, George V. Mann, M.D., associate professor of medicine, Vanderbilt University, said that in her best selling book "Let's Eat Right To Keep Fit," the "mistakes average one for each page."

The references cited by Mrs. Davis in another book "Let's Get Well," were checked by two nutrition scientists at the University of California at Los Angeles. Their analysis showed that in one chapter which listed fifty-seven references, in twenty-seven instances there were no data to support her statement.

Dr. Rynearson is concerned not only with the misleading aspects of faddism, he warns that it also can be dangerous. For example, Mrs. Davis suggested in "Let's Get Well" that patients with nephrosis should take potassium chloride. According to Russell Rand, M.D., professor of medicine and chief of the division of renal diseases, Medical College of Virginia, the suggestion is "extremely dangerous and even potentially lethal."

Turning his attention to Carlton Fredericks, a popular radio performer and writer of several books, Dr. Rynearson points out that Fredericks has had virtually no nutritional or health science training. Nevertheless, Fredericks advocates doses of Vitamin A that are toxic and can produce severe neurological damage.

The seventy-six page supplement—designed to be used as a reference by physicians, teachers, writers, and others who are called on for advice about nutrition and diets—includes official statements and reports issued by authoritative scientific organizations concerning the dangers of high doses of certain vitamins and of several unsound popular diets; excerpts from scientific and popular articles on other areas of faddism; and a list of recommended books and articles for laymen.

Copies of the supplement ("Nutrition Misinformation and Faddism") may be obtained from the Nutrition Foundation, 888 Seventeenth Street, N. W., Washington, D. C. 20006, for $2.50 each.

The American Society of Dentistry for Children, Central Pennsylvania Branch, is sponsoring a special program, "Aerobic Exercise and Health," to which physicians, their aides, and spouses are invited.

The program begins at 9 a.m. (registration at 8:30) on Saturday, November 16, 1974, at the Penn-Ram Motor Inn, 5401 Carlisle Pike, Mechanicsburg, and ends with luncheon, the price of which is included in the registration fee of $45 for physicians and dentists, and $15 for other guests.

Kenneth H. Cooper, M.D., of Dallas, Texas, author, lecturer, founder of the Institute of Aerobic Research, and director of the Cooper Clinic in Dallas, will speak.

Name _____

Address _____

City _____

Make check payable to and mail to: Dr. John Maynard, 1902 Market St., Camp Hill, PA 17011. All applications will be accepted, but no tickets or notice will be mailed to registrants. No refunds after November 1.

Physicians' offices excluded—for now

Rules in effect on ambulatory gynecological surgery

The Department of Health has published final rules and regulations on ambulatory gynecological surgery in hospitals and clinics. The rules which cover abortions were published Saturday, August 10, 1974, in the *Pennsylvania Bulletin*.

The revised rules reflect the recommendations of the State Society which termed the first draft "over-restrictive and exceedingly expensive." Physicians' offices are not covered by the standards, but this issue is still under consideration by a technical ad hoc committee headed by Virginia A. Washburn, M.D., 505 Pittsburgh State Office Building, 300 Liberty Avenue, Pittsburgh 15222. Telephone (412) 565-5085. This committee will also monitor the effects of the new regulations as they are implemented and make recommendations for changes, if necessary, to the Department of Health. Interested parties may direct their comments or suggestions to Dr. Washburn.

The new regulations apply to services provided "On an ambulatory basis in a hospital, hospital clinic, hospital satellite clinic, or a free standing facility of gynecological surgery, including any of the following procedures: culdoscopy, laparoscopy, diagnostic dilatation and curettage, dilatation and curettage, or vacuum extraction or other procedures for induction for abortion during the first trimester of pregnancy."

The clinic must have readily available equipment and drugs necessary for resuscitation. If local anesthesia is used the following equipment "should" be readily available: endotracheal tube, airway, resuscitation bag, cut down set, plasma expanders, oxygen, and emergency drugs.

When general anesthesia is used during the termination of a pregnancy, the following equipment must be available: defibrillator, direct writing electrocardiograph, tracheotomy set, endotracheal tube, airway, resuscitation bag, cut-down set, oral airway, plasma expanders, oxygen, and emergency drugs.

Emergency resuscitation procedures are to be performed only by a physician who "possesses the requisite professional skill and competence as determined and approved by the hospital or clinic in accordance with appropriate procedures."

At least one physician who is board eligible for the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology must be available either as a staff member or as a consultant "for the purposes of providing consultations as needed."

Before performing any procedures which might reasonably lead to the termination of pregnancy, appropriate methods must be used to determine positive evidence of pregnancy by test results, history and physical examination, or other reliable means. These findings must be entered in the patient's medical record.

Prior to the performance of a procedure which may lead to the termination of a pregnancy, the attending physician must insure that the patient has had a hemoglobin or hematocrit, complete urinalysis, blood group and RH type. These laboratory results are to be entered into the patient's medical records.

RH (D)-immune globin (human) shall be offered to each RH-negative patient at the time of any procedure which terminates pregnancy, unless contraindicated. This transaction or lack of it must be entered in the medical record.

All tissues removed during the pregnancy termination procedure shall be examined by a physician. More detailed examination may be ordered by the physician if deemed necessary. Any findings shall be entered in the patient's medical record.

The Rules say: "Each hospital and clinic shall offer screening tests for syphilis and gonorrhea. A screening test for cervical carcinoma may be offered and/or performed at the discretion of the examiner prior to pregnancy termination. Such screening is recommended post-pregnancy termination. Each facility shall provide treatment or referral treatment for any abnormal condition detected. Evidence of com-

Symposium for medical office aides

The third in a series of traveling symposia being presented by the Pennsylvania Society of the American Association of Medical Assistants will be held November 3 at the Abraham Lincoln Motor Hotel in Reading.

Prepared by the education certificate committee, topics include examining room techniques, sterilization procedures for the medical office, medicolegal responsibilities of the medical assistant, and reception suggestions.

Your medical assistant may be enrolled by contacting Mrs. Peg Flynn, CMA-AC, 710 Summerlea Ave., Washington 15301. The fee, which includes lunch, is $7.00.

pliance with this regulation shall appear in the patient's medical record. Each hospital or clinic shall offer to patients obtaining surgery for pregnancy termination a broad range of contraceptive services. Both optional contraceptive counseling and supportive counseling, as needed by patients shall be offered and made available on the premises or through referrals."

Each clinic must have standard arrangements with a hospital for the provision of emergency services. The location of the hospital holding the agreement to supply emergency services shall not be further than thirty minutes by ambulance from the clinic.

General and conduction anesthesia shall be administered by a physician or nurse anesthetist under supervision. Local anesthesia, including paracervical block, may be administered by the person performing the pregnancy termination procedure.

The rules call for constant supervision during the recovery period and specify that complications must be recorded in the patient's record and reported in writing to the Department of Health. Procedures not covered by the regulations are to be performed in a hospital, as are covered procedures if the patient has a medical condition indicating that the procedure should be performed on an inpatient basis.

Informed consent in writing is called for in the rules. Reports on first trimester abortions must be made monthly to the department on supplied forms. Pregnancies terminated at sixteen weeks or later are to be reported in compliance with regulations governing fetal birth and/or death certificates. Despite this required reporting, the rules provide for safeguarding confidentiality. Names of patients are not requested, and any data which might lead to the identity of patients "will be confidential," the rules state.

The regulations provide for an exception to any of the requirements if "good cause" is shown upon application. Applications denied may be appealed in accordance to the administrative agency law.

New Jersey Court sets contingent fees

Rules governing attorneys' contingent fees in negligence cases issued by the New Jersey Supreme Court have been upheld by an appellate court decision that limiting contingent fees in such cases (including malpractice suits) was within the power of the Supreme Court to regulate the practice of law.

The Supreme Court specified the following limits on contingent fee arrangements in negligence cases:

(1) 50 percent on the first $1,000 recovered;
(2) 40 percent on the next $2,000 recovered;
(3) 33⅓ percent on the next $47,000 recovered;
(4) 20 percent on the next $50,000 recovered;
(5) 10 percent on any amount recovered over $100,000 and;
(6) 25 percent on the first $50,000 if the recovery is a settlement without trial for an infant or incompetent.

The Supreme Court ruling resulted from the work of a joint committee of physicians and representatives of the court which began studying the escalation and inequities of contingent fees in 1967.

Upon issuance of the State Supreme Court Rules, several lawyers' associations brought an action to declare the rules unconstitutional. The associations presented no evidence at the trial, but the trial court ruled that the "fee limitations interfered with freedom of contract and unduly restricted attorneys' incomes."

It was a New Jersey appellate court which had the last word in the matter and sustained the rules limiting contingent fees in negligence cases.

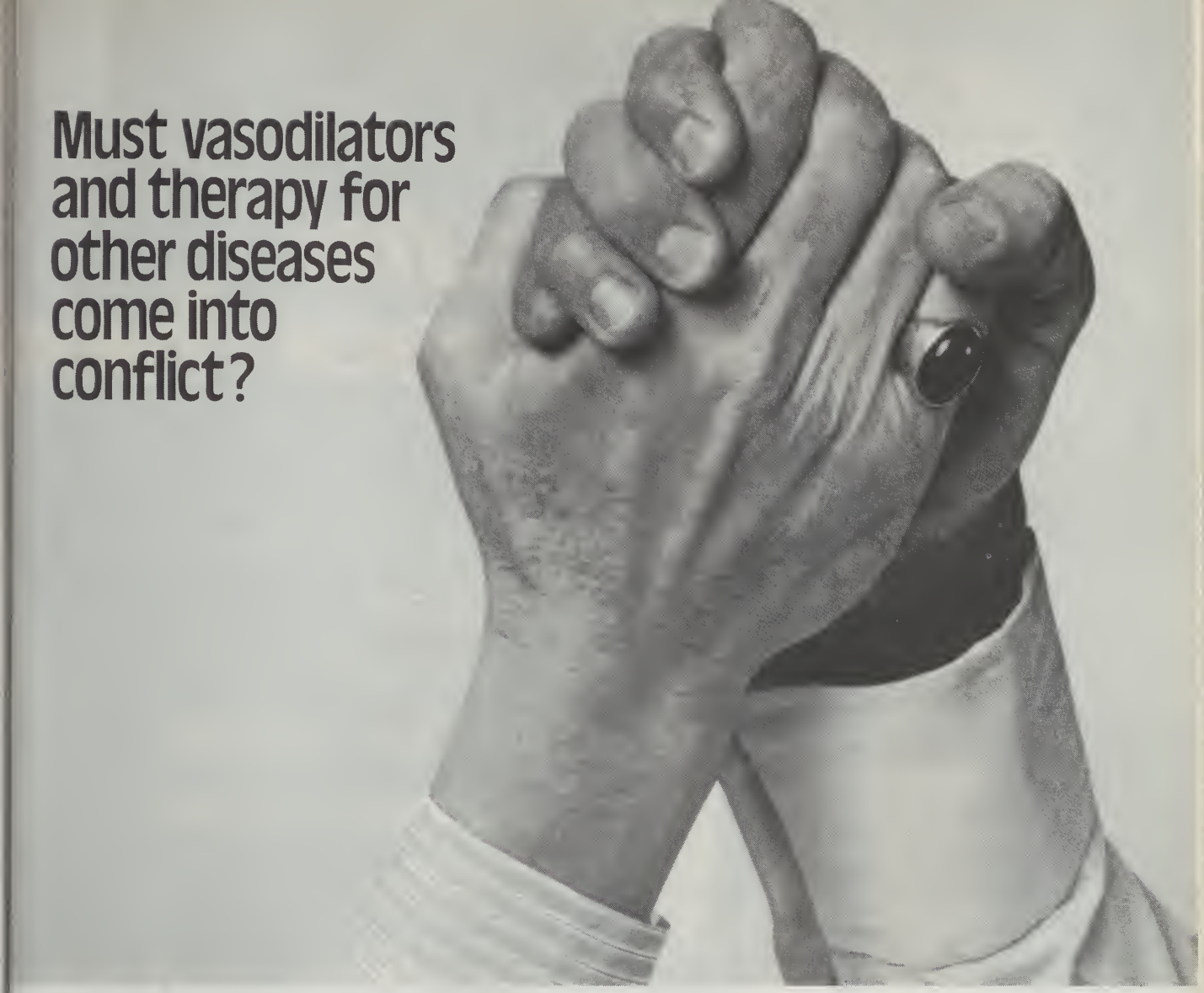
The appellate court said: "The state constitution clearly gave the Supreme Court the exclusive power to regulate the practice of law. The delegated authority included the power to adopt reasonable rules establishing the outer limits of permissible contingent fees in court litigation."

The New Jersey branch of the American Trial Lawyers Association in its brief claimed that the fee limitations violated their freedom of contract. The appellate court said: "Attorneys have never had the right to enforce contracts for more than a fair and reasonable fee. Membership in the Bar was a privilege burdened with the conditions imposed by the court and derived from an attorney's position as an officer of the court."

The trial lawyers added that singling out contingent fees to be so ruled was unfair. The court responded: "There was a reasonable basis for separating contingent fees from others . . . Contingent fee arrangements involve unique problems in the attorney client relationship, including those arising from that method of compensation which bore no direct relationship to the effort expended by the attorney or the value of his services."

The rules provide that an attorney may obtain a court hearing to request a higher fee if in his opinion the limitations have resulted in an inadequate fee.

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25:*134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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*Urethritis, cervicitis, proctitis when due to susceptible strains of *N. gonorrhoeae*

1973 The Upjohn Company J-3437-6

Trobicin—The advantage of injectable therapy.
Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

Trobicin—The aspect of privacy.
There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

Trobicin—Indication and dosage.
Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly†; 4 grams intramuscularly in females.

Trobicin—Not effective for syphilis.
Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic.
Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

...and Trobicin® 2 gm and 4 gm vials
sterile spectinomycin hydrochloride

Sterile Trobicin
Sterile Trobicin (spectinomycin hydrochloride) —For Intramuscular Injection:
2 gm vials containing 5 ml when reconstituted with diluent.
4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to spectinomycin.

Warnings: Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.
Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals.
Clinical effectiveness should be monitored to detect evidence of development of resistance by *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25° C and use within 24 hours after reconstitution with diluent.

Male—Inject 5 ml intramuscularly for a 2 gram dose. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female—Inject 10 ml intramuscularly for a 4 gram dose.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
Caution: Federal law prohibits dispensing without prescription.
For additional product information see your Upjohn representative or consult the package insert.

Upjohn MED B-5-S (MBR-I)
The Upjohn Company, Kalamazoo, Michigan 49001

† For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.

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THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

EASTERN PENNSYLVANIA OFFICE:

D. R. Lowe, L. R. Wilson, Jr., S. B. Elston, Jr., R. J. Nolen, Jr., and G. A. Baack, Representatives

Suite 101, The Benson Manor, Jenkintown 19046 Telephone: (215) 885-6090

WESTERN PENNSYLVANIA OFFICE: Ned Wells, S. T. Ingram, and D. C. Hoffman, Representatives

1074 Greentree Road, Pittsburgh 15220 Telephone (412) 531-4226

When **impotence** *due to*

androgenic deficiency

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**

2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓒ III Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

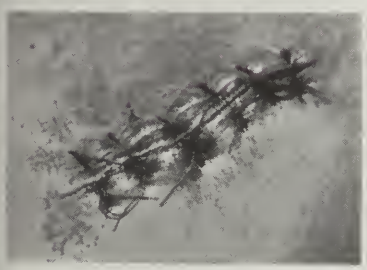
A. H. Robins Company, Richmond, Va. A·H·ROBINS

Healing nicely, but it still HURTS

HERE Burns

When parenteral analgesia is no longer required, Empirin Compound with Codeine usually provides the relief needed.

HERE Sutures



Empirin Compound with Codeine is effective for visceral as well as soft tissue pain—provides an antitussive bonus in addition to its prompt, predictable analgesia.

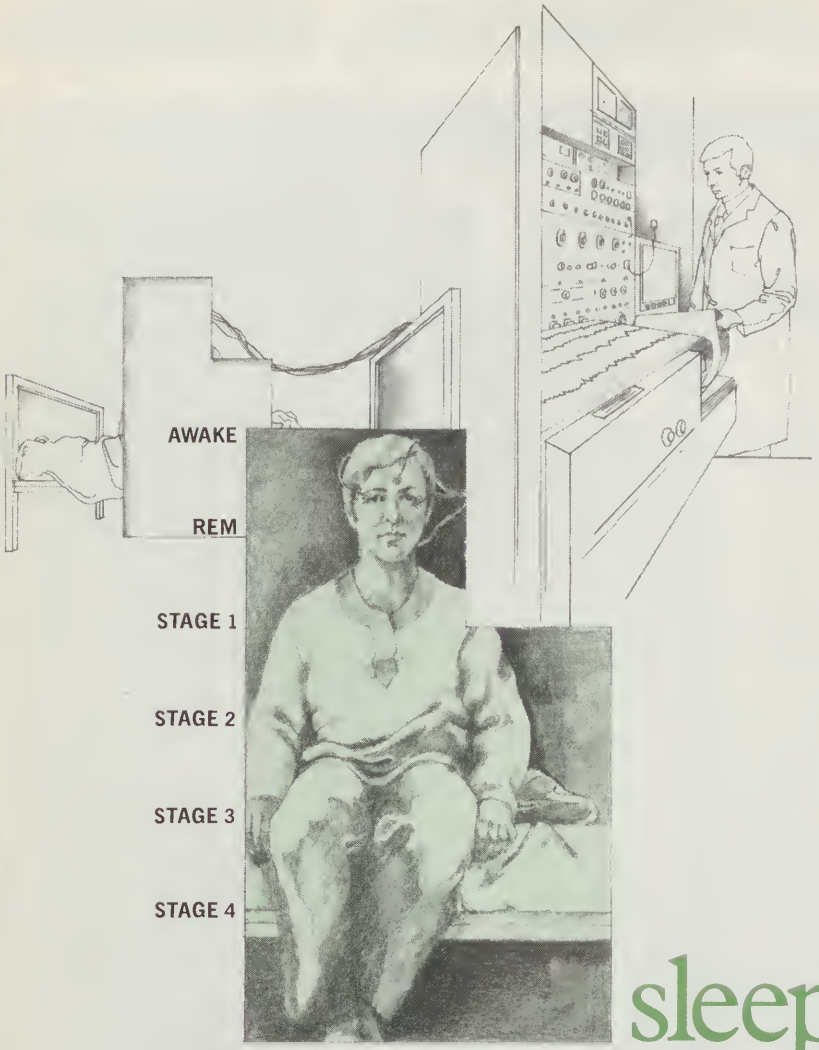
prescribing convenience: up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

Empirin Compound with Codeine **No. 3,** codeine phosphate* 32.4 mg. (gr. ½); **No. 4,** codeine phosphate* 64.8 mg. (gr. 1).*Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

Wellcome | **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

EMPIRIN® COMPOUND C̄ CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1



sleep begins within 17 minutes, on average ...

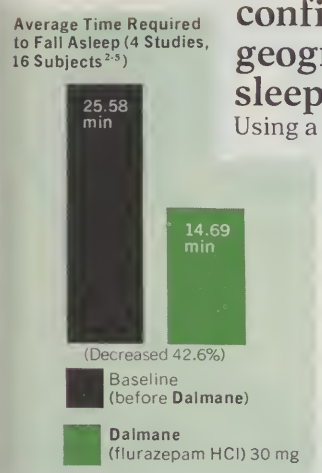
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories [2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

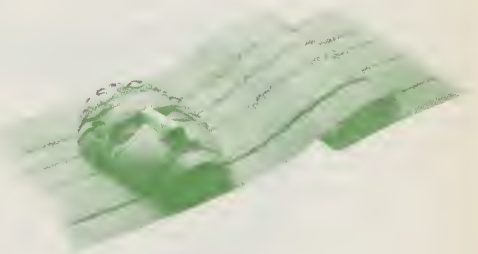
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

SK&F CO.
Carolina, P.R. 00630
Subsidiary of
SmithKline Corporation

KEEP THE HYPERTENSIVE PATIENT ON THERAPY
KEEP THERAPY SIMPLE WITH
DYAZIDE®

Trademark

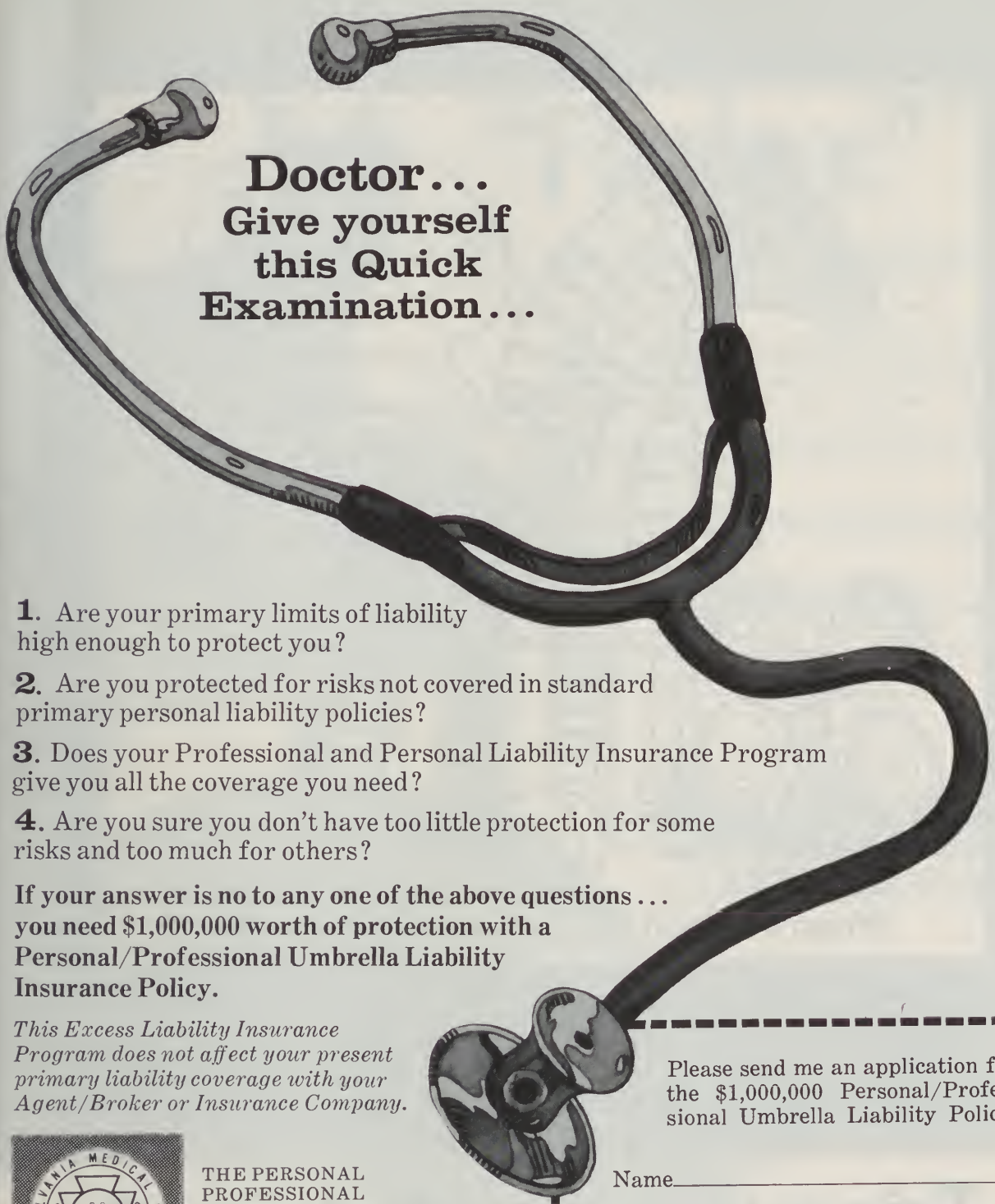
Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

No potassium supplements
No special K^+ rich diets
Just 'Dyazide' once daily or twice daily

Studies have demonstrated that two prime reasons patients drop out of hypertensive therapy are: (1) the patient failed to understand directions, and (2) the regimen was overly complicated.* Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

TO KEEP BLOOD PRESSURE DOWN AND KEEP POTASSIUM LEVELS UP



Doctor...
Give yourself this Quick Examination...

1. Are your primary limits of liability high enough to protect you?

2. Are you protected for risks not covered in standard primary personal liability policies?

3. Does your Professional and Personal Liability Insurance Program give you all the coverage you need?

4. Are you sure you don't have too little protection for some risks and too much for others?

If your answer is no to any one of the above questions... you need $1,000,000 worth of protection with a Personal/Professional Umbrella Liability Insurance Policy.

This Excess Liability Insurance Program does not affect your present primary liability coverage with your Agent/Broker or Insurance Company.

THE PERSONAL PROFESSIONAL UMBRELLA LIABILITY INSURANCE PROGRAM HAS BEEN ENDORSED BY THE PENNSYLVANIA MEDICAL SOCIETY

ADMINISTRATOR

ALEXANDER AGENCY INC.

INSURANCE WORLD-WIDE SINCE 1853
Union Bank Building, Pittsburgh, PA. 15222

Please send me an application for the $1,000,000 Personal/Professional Umbrella Liability Policy.

Name_____

Office Address_____

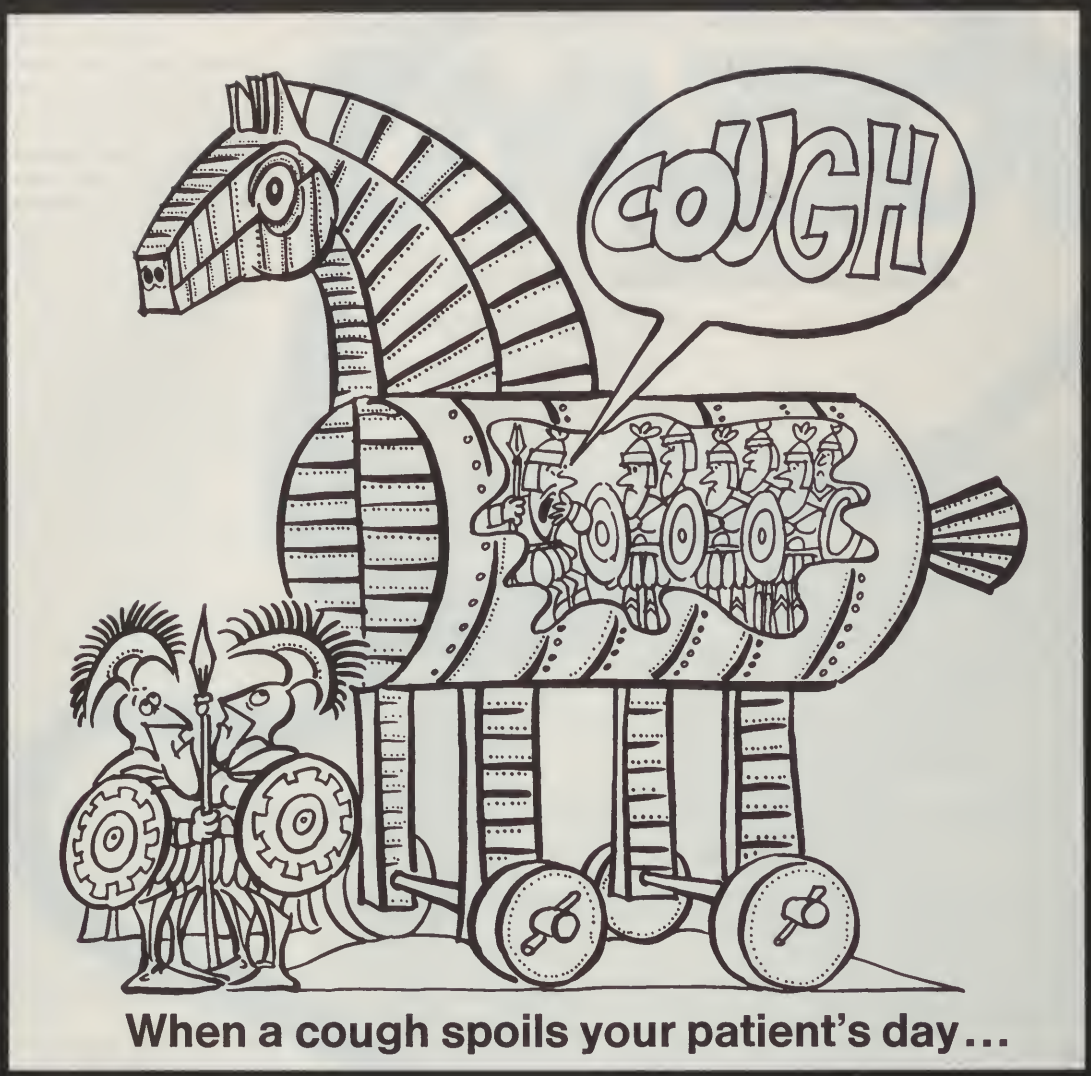
_____

City_____

State_____ Zip_____

Telephone_____

Mail to: ALEXANDER AGENCY, INC.
Union Bank Building, Pittsburgh, PA. 15222



When a cough spoils your patient's day...

Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Available in 8-oz. Family Size and 4-oz.
No Rx needed—recommend over the phone.

The Adult Expectorant that is great for kids, too.

Dorsey Laboratories/Division of Sandoz-Wander, Inc./Lincoln, Nebraska 68501

BO-SD

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol C III SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL
McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

WARNER/CHILCOTT
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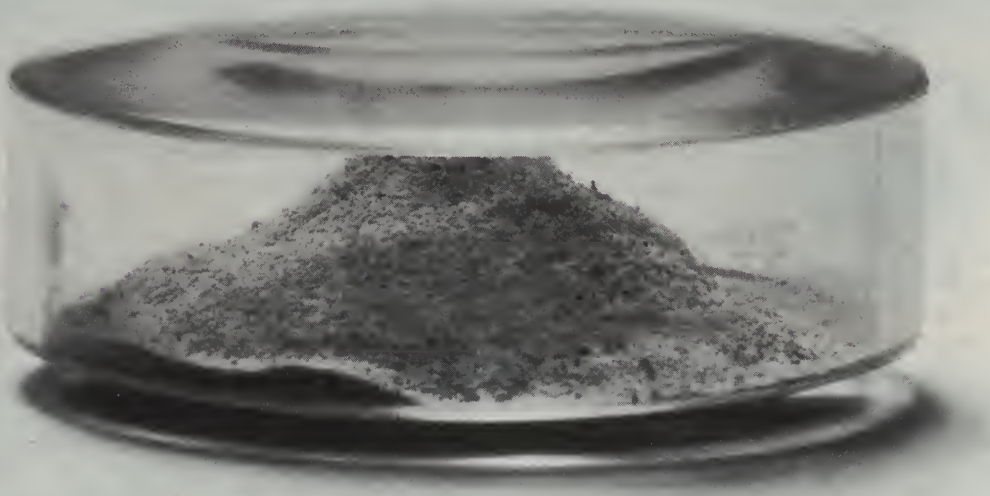
Morris Plains, New Jersey 07950

IN NATURAL THYROID THERAPY:

ARE PATIENTS GETTING THE POTENCY YOU PRESCRIBE?



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cardiovascular brief

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THE UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE May 9-10-11, 1975

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Basic life support; using adjunctive equipment and special techniques, such as endotrachael intubation and open chest internal cardiac compression; cardiac monitoring for dysrhythmia recognition and control; defibrillating; establishing and maintaining an intravenous infusion lifeline; employing definitive therapy, including drug administration (a) to correct acidosis and (b) to aid in establishing and maintaining an effective cardiac rhythm and circulation; stabilization of the patient's condition.

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M.D.s in the news

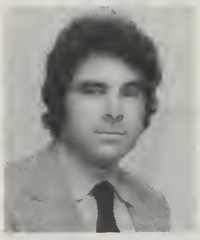
Aaron E. Fishman, M.D., Philadelphia, who has been elected to the Board of Regents of the American College of Allergy, co-chaired an allergy panel at the recent annual congress of the American College of Allergists in Paris, France. He also attended the college's postconvention seminar in Stratford-on-Avon, England.

The Philadelphia Academy of Ophthalmology and Otolaryngology installed new officers at the society's recent convention. They are **Robert D. Mulberger, M.D.,** president; **Louis E. Silcox, M.D.,** president elect; and **Albert F. Cleveland, M.D.,** treasurer. **James B. Snow, M.D.,** was elected a director of the academy. Dr. Mulberger is chief of ophthalmology at Presbyterian University of Pennsylvania Medical Center and attending surgeon and chief of corneal service at Wills Eye Hospital.

Daniel Freeman, M.D., Rydal, has been appointed director of the department of education at Philadelphia State Hospital. He was formerly research consultant in cross-cultural psychiatry in the research department of the children's unit at Eastern Pennsylvania Psychiatric Institute.

Robert E. Lee, M.D., associate professor of pathology at the University of Pittsburgh School of Medicine, has been appointed director of laboratories for Presbyterian-University Hospital, Pittsburgh. He succeeds **Robert Totten, M.D.,** professor of pathology at the University of Pittsburgh School of Medicine, who has become director of cancer programs in pathology at the University Health Center of Pittsburgh. Both physicians are diplomates of the American Board of Pathology, and members of the American Association of Pathologists and Bacteriologists, the American Society of Clinical Pathologists, and the International Academy of Pathology. Dr. Totten is a past president of the Pennsylvania Association of Clinical Pathologists and the Pittsburgh Pathology Society.

Harvey A. Horowitz, M.D., Wynnewood, has been named associate director of the adolescent treatment unit of the Adolescent Treatment Center at the Institute of Pennsylvania Hospital.



DR. HOROWITZ

DR. BURNS

Rosalie Burns, M.D., acting chairman of the Medical College of Pennsylvania department of neurology, has been appointed professor in neurology. She was formerly on the faculty of the Cornell University School of Medicine, New York City, and continues as consultant at the Eastern Pennsylvania Psychiatric Institute.

D.E.Darnell Jones, M.D., and **John Fontana, Jr., M.D.,** have joined the department of obstetrics and gynecology at the Milton S. Hershey Medical Center, Pennsylvania State University. Dr. Jones was previously chief of obstetrics and gynecology at U.S. Mumson Army Hospital, Fort Leavenworth, Kansas. Dr. Fontana was former head of obstetrics and gynecology at Cherry Point Naval Hospital, Cherry Point, N.C.

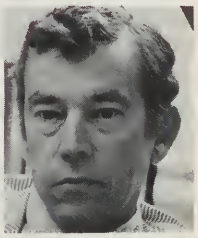
Stephen H. Miller, M.D., former assistant professor of surgery at the University of California School of Medicine at San Francisco, has been appointed associate professor of surgery in the division of plastic and reconstructive surgery at Milton S. Hershey Medical Center, Pennsylvania State University. He is certified by the American Board of Surgery and the American Board of Plastic Surgery and is a fellow of the American College of Surgeons, the American Society of Plastic and Reconstructive Surgery, and the Association of Academic Surgery.

A new book entitled "Self-Assessment of Current Knowledge in Cardiothoracic Surgery" has been written by **G. Frank O. Tyers, M.D.,** associate professor of surgery at the Milton S. Hershey Medical Center of Pennsylvania University. It is designed primarily to instruct and only secondarily to test a physician's knowledge of cardiovascular and thoracic diseases. Dr. Tyers is a fellow of the Royal College of Surgeons of Canada and is certified by the American Boards of Surgery and of Thoracic Surgery.

Volker Breitfeld, M.D., assistant professor of pathology at the University of Pittsburgh School of Medicine, has been named director of the division of hematopathology at the University Health Center of Pittsburgh. He was previously assistant director in the center's central hematology laboratory. Dr. Breitfeld is a member of the American Society of Clinical Pathologists and the College of American Pathologists.

Diane E. Schuller, M.D., has joined the permanent staff at Geisinger Medical Center, Danville, as an allergist in the department of pediatrics.

DR. SCHULLER



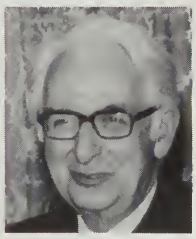
DR. CORTNER

Jean A. Cortner, M.D., has been appointed physician-in-chief of the Children's Hospital of Philadelphia and has been designated William H. Bennett professor and chairman of the department of pediatrics at the University of Pennsylvania School of Medicine. Dr. Cortner was previously professor and chairman of the department of pediatrics at the State University of New York, Buffalo, N.Y., and physician-in-chief of the Children's Hospital of Buffalo. He is a diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics.

M.D.s in the news

Thomas D. Duane, M.D., ophthalmologist-in-chief at Wills Eye Hospital and chairman of the department of ophthalmology at Thomas Jefferson University, has been asked to serve on the grants advisory council of the Seeing Eye, Inc., an organization for training dog guides and their owners.

DR. DUANE



DR. FARRAR, JR.

George E. Farrar, Jr., M.D., has been named director of medical affairs for *Excerpta Medica*. He is a past president of the Pennsylvania Medical Society and the Philadelphia County Medical Society. Currently he serves as vice chairman of the PMS Judicial Council.

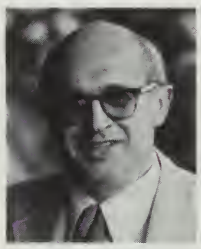
Doris G. Bartuska, M.D., associate professor of medicine and director in the division of endocrinology and metabolism at Medical College of Pennsylvania, has been appointed associate dean of the college. Dr. Bartuska is a diplomate of both the Board of Internal Medicine and the Board of Endocrinology and Metabolism and is the recipient of the 1974 Christian R. and Mary F. Lindback award for distinguished teaching.

Joseph J. Thomas, Jr., M.D., has joined the permanent staff in the department of neurology at Geisinger Medical Center, Danville. He was formerly an assistant professor and attending neurologist at the University of Arizona Medical Center. **Merrill C. Raikes, III, M.D.,** has also joined the staff in the department of radiology. He has completed his residency at the University of Maryland Hospital in Baltimore, Md.

John Helwig, Jr., M.D., chief of the cardiovascular section at the Germantown Dispensary and Hospital, Philadelphia, has been promoted to clinical professor of medicine at Temple University School of Medicine. Dr. Helwig is currently chairman of the PMS Council on Medical Service, a delegate to the State Society, and an alternate delegate to the American Medical Association.

The Robert H. Ivy Society of plastic surgeons has elected **William P. Graham, III, M.D.,** professor and chief of the division of plastic and reconstructive surgery at the Milton S. Hershey Medical Center of Pennsylvania State University, as its new president. **Frank Tooze, M.D.,** Erie, has been elected vice president. He is a clinical assistant professor of surgery at the medical center and directs its plastic surgery residency program at Hamot Hospital in Erie.

Robert F. Plotkin, M.D., Broomall, has been appointed director of the department of pediatrics at Bryn Mawr Hospital, Bryn Mawr. Dr. Plotkin is a diplomate of the American Board of Pediatrics, a fellow of the American Academy of Pediatrics, and a member of the board of directors of the Philadelphia Pediatric Society.



DR. PLOTKIN

DR. COODLEY

Eugene L. Coodley, M.D., has been named associate chairman for graduate training in the department of medicine at Hahnemann Medical College and Hospital. He will be responsible for the residency training program and will serve as director of internal medicine. Dr. Coodley is a diplomate of the American Board of Internal Medicine and a fellow in the American College of Physicians, the American College of Angiology, the American College of Cardiology, and the American College of Gastroenterology.

The psychiatric department of Medical College of Pennsylvania has announced that eight members have been elected to posts in psychiatric organizations: **Leo Madow, M.D.,** professor and chairman of the department, has become president of the Philadelphia Psychoanalytic Institute, a member of the board of directors of the Group for the Advancement of Psychiatry, and has been named a life member of the Philadelphia Psychiatric Society and the American Orthopsychiatric Association. **Selma Kramer, M.D.,** professor of psychiatry, is chairman of the Committee on Child Analysis, the American Psychoanalytic Association, and member of the board of directors of the Philadelphia Psychoanalytic Institute. **O. Eugene Baum, M.D.,** professor of psychiatry, is councilor of the Philadelphia Psychiatric Society. **Laurence H. Snow, M.D.,** professor of psychiatry, has become a fellow of the American Psychiatric Association. **Ralph Little, M.D.,** clinical associate professor of psychiatry, has become president of the medical staff of the Psychiatric Institute of Pennsylvania Hospital and secretary of the Philadelphia Psychoanalytic Institute. **William R. O'Brien, M.D.,** clinical associate professor of psychiatry, has been named a member of the board of directors of the Philadelphia Psychoanalytic Institute and a life member of the Philadelphia Psychiatric Society. **Barry J. Schwartz, M.D.,** clinical assistant professor of psychiatry, is a fellow of the American Psychiatric Association and president elect of the Philadelphia Association for Adolescent Psychiatry. **LeRoy J. Byerly, M.D.,** clinical assistant professor of child psychiatry, is program chairman of the Philadelphia Psychiatric Society.

Joseph C. Maroon, M.D., has been promoted an associate professor of neurosurgery at the University of Pittsburgh School of Medicine. His main research interests are in the study of nerve regeneration and stroke.

editorials

People or money—government will choose

It is a sad, but true, fact that the future course of medicine in our country is being progressively determined by nonmedical personnel. The repeated attempts to reform the "outmoded cottage industry" that has composed our medical care system since the 1700's have been made by Senators and Congressmen who are far removed from the medical world. Not only are there no physicians who are in positions of leadership in the United States political system, but there is likewise no cabinet level post which is solely health related. Congressional committees which control health and related areas are primarily the finance and appropriations committees of both houses. Finance committees propose tax revenues, while appropriations committees dole out the funds. Our health care laws seem to be fostered on dollars and cents criteria rather than what-is-best-for-the-patient criteria. The Senate Labor and Public Welfare Subcommittee on Health, chaired by Senator Edward M. Kennedy, is a division of the Senate Finance Committee. The dollar controlling committees of Congress will most surely be those with the strongest voice in the formulation of health care legislation because it promises to be the proverbial gold-mine.

A superb example of the dollar based health care proposals is the recent move by Congressional leaders to change the prescribing methods to generic rather than trade names so that the patient might have the benefit of purchasing the cheapest available drug. A fantastic idea on paper, one wishes this practice were as easily accomplished in the real world. Nonmedical experts base their bargain shopping claims on the amount of *active* ingredient in a given drug. Although active ingredients may be similar or even identical, the drug efficacy may differ. Very few drugs are pure. Most are compounds made up of a number of so-called inactive or inert components such as binders or preservatives. These components, as well as the process by which the drug is manufactured, influence the decomposition and eventual rate of absorption of the active ingredient into the body. It is possible, depending upon the manufacturing process, to have the same drug from the same company behave in a different manner from the batch previously produced.

The physician, by virtue of his training, is familiar with the efficacy of drugs and in particular with the specific drug which he prescribes for a given ailment. If bargain shopping for drugs is nationally mandated, then the physician will lose some control over his patient's course of therapy. Several years ago a television advertisement proclaimed that "you get what you pay for." If product selection based on dollars and cents is the goal, so be it. Physicians should then seek legislation to protect themselves from the failures of therapeutic courses where their judgements are overturned for a less expensive product.

Let us hope that we never need to seek such protection. Health care is not an industry that can be measured in monetary figures. Health care deals with lives upon which no dollar value can be placed. The public must realize that you never get something for nothing. Nonmedical experts on health care are not just shuffling money from one coffer to another, but they are dealing with the lives of over one hundred million people. Such a thought ought not to be taken lightly, and action certainly should not be initiated without qualified medical advice.

David A. Smith, M.D.
Medical Editor

Medicaid review in order

Since its enactment in 1965, medicaid has provided "free" medical care to an increasing number of poor individuals and families in Pennsylvania. With this, of course, comes an increase in the cost of the program, which some state officials would readily tag to physician's greed and dishonesty rather than looking objectively at the situation to determine wherein the true problem lies. There are, in every profession, individuals who will attempt to make a dishonest dollar given the opportunity, but this hardly constitutes the majority. It does not follow that all doctors are thieves.

Several explanations for the increased costs of the Medical Assistance Program come to mind readily, not the least of which is the present state

of the economy. High rates of unemployment over the past few years qualifies more families for welfare, hence medical assistance. Greater tax deductions have been allowed by the federal government, thus decreasing the tax base and the amount of money which is available to be channeled into medical programs. Just as inflation is a problem in every household, inflation is a problem for government programs also. More cash is now required than was in 1965 or even 1970 to pay for services because of the depressed value of the dollar. All of these influence medicaid costs.

There are other problems which government officials would like to ignore. It is sometimes easier to place the blame on others than to admit responsibility and search for solutions. Title 19, like all other governmental programs, has developed a bureaucracy which must be paid. With all the additions, revisions, corrections, and restrictions that are constantly being made in the medical assistance law, administrative costs must necessarily rise. Any saving gleaned from utilization review procedures in hospitals is soon gobbled up in the administrative bureaucracy. Inappropriate utilization is a problem but it takes both time and money to detect. Coupled with the changing concept of what is an allowable admission or a reimbursable cost, one wonders whether current methods are not costing more than if utilization review were not done at all.

Another interesting, but salient, point to ponder is that the medicaid law was foisted upon the medical profession by well-meaning, but a trifle too overzealous, legislators. It must be admitted that one is much more likely to internalize change if one is permitted a voice in the change or a hand in formulating it. PSRO has a much better chance of success since physicians will "police" the activities of their own. Medicaid, as such, has no internal controls. Nearly all federally administered programs of this nature cost more in the long run than were initially estimated.

If medicaid has become an intolerable financial burden, then it is time for state officials and physicians to sit down to a frank, honest discussion of problems and to look for reasonable, workable solutions. It will not be easy, and there will be no panacea. To say that physicians are entirely responsible for the problems is to say that the medical profession is dishonest in its financial dealings, a premise which can only create animosity and further widen the breach between physicians and the government.

David A. Smith, M.D.
Medical Editor

correspondence

Opposes Society's abortion position

To the editor:

Having just read the August 1974 issue of Pennsylvania Medicine with specific reference to the article "Health Care in Pennsylvania 1974" regarding the position of the Pennsylvania Medical Society as presented to the major political parties in the state for their consideration in the drafting of their respective party platforms as they relate to the health care of the people of the Commonwealth adopted by The Board of Trustees and Councilors, May 15, 1974, I am somewhat chagrined.

With specific reference to the policy of the Society with regards to abortion as stated on page 36, it is obviously a gross misrepresentation of the Society's opinion unless it is the intention of the Pennsylvania Medical Society to violate the Supreme Court's decision, in which case the Society's statement of policy could be considered accurate.

I am sure I need not inform you that at no place in the statement regarding the Society's policy with regard to abortion is anything listed regarding the gestation or period of pregnancy, which is grossly misleading to any lay person.

Even in my type of practice, I am in contact with people on a daily basis who are unaware that an abortion during the first trimester or until a period of twelve week's gestation, the decision for abortion rests with the woman and her doctor.

Only for the second and third trimester abortion, state laws may regulate the abortion procedure in ways that are reasonably related to maternal health. I am sure that you are familiar with the statements, as this was the decision by the Supreme Court on January 22, 1973.

I am sure there are many other members of the Pennsylvania Medical Society who would be in complete agreement with my statements.

I wish to go on record as stating that I am 100 percent against the statement as printed regarding the policy of the Society with regard to abortion and as supposedly adopted by the Board of Trustees and Councilors, May 15, 1974.

Richard K. Kleppinger, M.D.
West Reading

Recruiting and hiring aides

LEIF C. BECK, LL.B.
Bala Cynwyd

A practice's success, both professional and financial, depends so much on its personnel that I often wonder why doctors give so little attention to it—to *personnel administration.* This article will consider some aspects of that subject, with my admonition that if the doctor or doctors in a practice approach it conscientiously, there should be no real excuse for having less than a competent and personable staff.

If there is any one element of personnel management which is overlooked by doctors, I believe it is in conscientious recruiting and hiring of new employees. Medical practices simply too often approach the recruiting and hiring process as a casual matter. Instead, there should be a *specific, prearranged* routine for employing any new aide, and it should not be short-cutted merely because a promising applicant has been located.

Recruiting Applicants

The first aspect obviously involves recruiting—looking for satisfactory applicants. The answer to the "where to look" question will vary from place-to-place, but the best answer is to try all available approaches. One never knows where the "right" person might be found.

Placing ads in all the area newspapers (both daily and weekly) is one obvious recruiting step. In areas surrounding our largest cities, the ads should be placed in both the big city papers and the local suburban papers. The ad should describe the job category *broadly* ("medical assistant," "secretary in medical office," etc.) to encourage inquiries. It should state whether experience in a medical office is needed, although in most cases I believe it is better to specify that it is *not* necessary. I also suggest that the ad *refrain* from quoting salary for the job, since (at least in smaller offices) it should be kept flexible depending on the circumstances of the person who may be hired.

Employment agencies are another potential source of applicants, although many experiences with them have been disappointing. Although the agencies claim to screen the applicants before recommending them, the persons sent out often seem to be ill-suited for the job. Accordingly, the persons they recommend should be considered to need the same preliminary screening as are applicants from newspaper ads.

Finally, another sometimes successful source of new help is "piracy"—offering employment to a person already employed, perhaps at a local hospital or at another medical office. Doctors so often conclude that aides working in their occasional presence at the hospital, for example, will be ideal for their private office. Unfortunately, however, those aides might turn out to be entirely inadequate for the job change. This defect could often have been avoided had the person enticed from a known employer been screened as carefully as newspaper ad applicants. Thus this general rule: Never short-cut the application process by prematurely hiring a person just because of some personal knowledge. Keeping that person in the same routine as all other applicants and assuring that she understands that she is being considered along with others can thus avoid embarrassment.

Screening Applicants

I believe all persons interested in a job offer should first be required to telephone a specific office aide for preliminary screening. If there is an office manager, the screening would be her obvious duty. If not, a trusted aide should be assigned that job. This person should have a specific list of simple questions to be asked, she should answer the applicant's initial questions, and she should be expected to decide for herself whether to invite the applicant to the office for an interview. This last point is extremely important, for telephone screening will help avoid the wasted time of interviewing people obviously ill-suited for the open job or for the office environment.

Having the screening and many of the later functions handled by aides is important for several reasons. First, of course, the doctors in the office should be spared administrative details as a matter of time efficiency. They presumably have far more vital demands on their time than routine screening.

Even if the doctors had the time, however, I would urge delegating the responsibility as a means of involving their aides in the office's well-being. The aide actually hired will probably be most valuable if she is

Mr. Beck is President of Management Consulting for Professionals, Inc., Bala Cynwyd, Pennsylvania.

well-accepted by the rest of the staff—the new and old staff employees must spend more time working together than must the doctor or doctors. As a result, I believe that involving the present aides in the selection process and respecting their opinions will substantially increase the chances of having a compatible office staff. Inviting an aide's discretion in initial screening is thus a first step in following this principle.

Initial Interview

Those persons selected to come into the office for an interview should, in my view, be scheduled to meet with one or more of the aides—not with the doctor or doctors. This is an extension of the same two purposes described above: saving doctor time and involving the staff in office success. The interview should thus be scheduled for a time when the staff is least busy, which would normally be when there are no office hours.

While the office manager or senior aide who did the telephone screening should conduct the interview, I would urge that other aides be brought in as well. This has the advantage of letting more of the staff evaluate the applicant from a personality standpoint (which I consider far more important than her initial technical competency). It similarly offers the applicant a better feeling of the office environment, which hopefully will impress her enough to want the job.

The office interview should begin by having the applicant fill out a preprinted application form. That form should be quite extensive, including many routine questions (personal history, health history, education, previous employers, etc.) and some general ones. The general questions would be good leads to items for discussion during the interview. The form should also specifically ask why the applicant left her prior jobs and what she liked or disliked about them. Since I urge checking with prior employers before hiring anyone, the applicant's answers to questions about her past jobs can be compared with the employers' own views. This tests the applicant's *honesty* as well as her employment history.

One question which should appear on the application form is the person's salary expectation. No more than a broad salary range should be stated in reply to the applicant's inquiry, perhaps over the telephone, so that a proposed salary figure would have first been specified by the applicant (on the form) rather than by the employer. This has obvious advantages to the employer.

The interview itself should be a two-way matter. Your senior aide(s) should ask some questions about the applicant's experience for the job in question and some general questions merely to develop a feeling for the applicant *as a person*. The general questions on the application interview (last book read; favorite recreational activities, etc.) should be good leads for this discussion. At the same time, the applicant should be encouraged to inquire about the job, its conditions and characteristics, the nature of the practice, and so on. It should at all times be remembered that the applicant is evaluating the job just as much as the employer is evaluating her!

Skill Testing

Whenever the job involves specific skills, the applicant should be given a brief (perhaps 10 minutes) test to determine at what level her skills really are. Medical employers seem forever shocked that some persons hired as experienced typists are not as proficient as expected, that some licensed nurses have less capability than prior nonlicensed aides, and the like. One way to avoid the disappointment is to see for one's self what the applicant's skills really are.

As to jobs requiring typing, a skill test is simple. If most typing work is from dictated tapes, a short sample tape should be dictated for each applicant to transcribe. Care should obviously be exercised that the tape not be overloaded with terms unique to the specialty practice, which any typist can only learn through prior work in that specialty.

Bookkeeping, receptionist, and medical assistant jobs require greater ingenuity in the design of a "home made" skill test. They can usually be accomplished with some degree of usefulness, however, and probably the best approach is to ask the aides themselves to design such tests. In addition to involving the staff in the office's personnel decisions, such a delegation also encourages them to review their own job functions.

Physician Interview

After a number of applicants have been screened, tested, and interviewed by the responsible aides, the doctor (or the managing doctor of a group practice) should meet with those aides for a review session. The aides would then hopefully report that they recommend a limited few persons for a follow-up interview with the doctor. While the doctor may properly inquire into the rejected applicants and the reasons for the aides' decisions, only in rare instances should he overrule

QUESTIONS? SUGGESTIONS!
are invited for consideration by
The Committee on Objectives
Pennsylvania Medical Society

Send to:
Committee on Objectives
Pennsylvania Medical Society
Box 301, Lemoyne, PA 17043

(Name)

(County)

them—the aides have to work with the newly hired employee even more closely than does the doctor.

I believe that the doctor's interview should be open to his aides, at least to the one or two aides that had done the earlier work. There should be nothing to hide in the interview, and both present staff and potential employee ought to have a feeling that the office operates informally and openly.

A variety of subjects need be covered in this doctor interview. On the one hand, the doctor should draw the applicant into discussion about herself, her thought patterns, prior work experiences and the like. He should be particularly sensitive to her descriptions of her previous employers, what she liked or disliked about the jobs, and why she left them. These comments can be compared to her answers on the application form and also to comments upon calls to those employers for consistency and honesty. They also can be evaluated to consider whether there are any similarities in the job being offered which may cause the aide to become dissatisfied with it as well.

On the other hand, the doctor should be sure that the job and all personnel policies are well-described to the applicant and that all her questions are answered. This would include stating an initial salary offer, which should have been decided upon during the advance discussion between the doctor and his aides. *No offer should be made during this interview,* but all details should be discussed to determine if they will probably be acceptable if that applicant is chosen.

This doctor interview need last only twenty to thirty minutes, so that several could be scheduled in succession if at all possible. At the end of the interview, the applicant should be thanked for coming back a second time and assured that she will be notified within a stated number of days, no more than one week. And out of good faith to the applicant, this promise must be kept!

Even if one applicant seems clearly to stand out as the "perfect choice" she should not be offered the job at that interview. Courtesy and continued involvement of the aides demand that the doctor review the decision with them, thus attempting to make the decision a joint one. And even if the aides disagree with the doctor's final decision, they will at least have had the satisfaction of knowing that he sought and considered their views. Furthermore, no person should be hired until after her references have been checked—which would best occur after the doctor interview.

Reference Check

It should be an absolute rule that an applicant will not be hired without checking her references. At least her immediate prior employer, and often the one before that should be checked. This check should be made by the doctor himself and should be by telephone—never by mail. Even a person whose present employer is unaware that she is seeking another job should be checked at this late stage. If she is close to being hired for a new job, she should accept the embarrassment as inevitable anyway. And the new employer must insist on the right to protect himself by following up on a person's work history.

We would appreciate your using the standard codes for emergencies rather than yelling 'get a move on, doc!'

The reasons for telephone checking should be obvious. A previous employer is often and understandably unwilling to state something unfavorable about a person in writing. And by telephone, the doctor can detect hesitations, inflections and the like, which should lead him to explore his question further.

The reference check should include some specific questions: What were the person's job and duties? How did she discharge them? What was her final salary? Why did she leave that employer? Would the employer rehire her? Some of those questions should be compared to the applicant's answers provided in her application and/or interviews. Any answer not wholly satisfactory should, of course, be followed up by additional questions. Such discussion will rarely take the doctor more than a couple of minutes, but the value of reducing the chances of a hiring mistake is tremendous.

Conclusion

If the reference check on the selected person has been satisfactory, she should then be offered the job on the terms discussed at the doctor interview. Assuming she accepts, the other "final round" applicants should be notified with thanks. Their information should, however, be kept on file since the thoroughness of this interview process might well have branded one or more of them as excellent candidates if another job should open up in the office.

While this entire process may appear time-consuming for a small medical office or for a search for an aide of only moderate technical skills, it is time well spent. The physician-time, however, would have been kept to a minimum despite the thoroughness of the effort. And the emphasis during the entire process would have been on staff involvement to emphasize that a compatible group of employees are most likely to create the best office.

Teaching family medicine: Progress report

THOMAS L. LEAMAN, M.D.
ROBERT L. BAUER, M.D.
HIRAM L. WIEST, M.D.
Hershey

THE DEPARTMENT of family and community medicine of the Pennsylvania State University College of Medicine published its first report, "An Experiment in Teaching Family Practice: Preliminary Report," in the May 1968 issue of PENNSYLVANIA MEDICINE. Since this description was in the tentative terms of an "experiment," it seems appropriate that a five-year follow-up report should be made in the same journal. Accomplishments, progress toward long and short term objectives, and a summary of current and foreseeable problems will be presented.

The authors' pictures as printed in the 1968 report and more recent photos are included. However, no effort will be made to explain any noted differences.

Changing Milieu

When the department of family and community medicine was organized in September 1967, it was the first department anywhere teaching family medicine to predoctoral students. There were fewer than five family medicine residency programs, and the American Board of Family Practice had not yet been founded. There are now approximately thirty-five departments of family medicine in medical schools, about twenty-five divisions of other departments devoted to family medicine, and an equal number in the planning stages. Family practice became a recognized specialty in 1970, and there are now 205 approved residency programs.

Practice responsibilities of the department have rapidly increased and now include about 11,000 patients from the nearby area. The departmental faculty includes ten full-time and two part-time physicians, as well as three physicians' assistants, and thirty clinical appointees, including most of the local practicing physicians. The practice is conducted in two units, one within the main medical center building, and a second in a converted student apartment building on the edge of the campus.

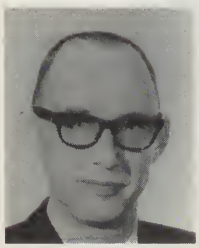
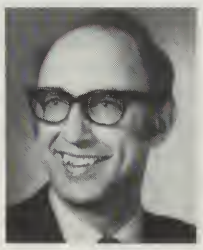
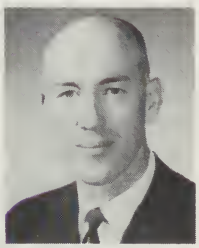
Predoctoral Teaching Program

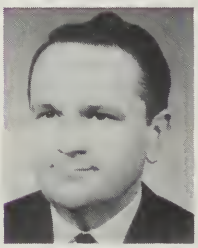
The teaching program* for first and second-year medical students continues to be a required part of their curriculum. However, specific methods have undergone continued development and revision as a result of our changing capabilities and awareness of teaching methods and in response to students' needs. One of the basic teaching tools remains the assigned patient family. Each student is assigned a family during the first year of school with whom he learns to develop his own patient-student-doctor relationship and with whom he has the opportunity to observe continuity of care, use of the patient-doctor relationship, and intrafamily psychodynamics. A series of weekly seminars is conducted centering about areas of particular interest in family practice. There is also a series of correlation conferences in which patients from the practice are presented as whole people (members of a family) and their problems discussed by members of other departments in both the clinical and basic sciences in an effort to relate teaching in these areas to real people.

An honors program is also offered each year for five to eight students to study and participate in health care delivery in an underdeveloped country for two to three months.

In a program shared with the departments of medicine and pediatrics, preceptorships are available in each of the primary care specialties. A student during the first or second year may spend one week with a carefully selected preceptor, or in his third or fourth

* *Supported in part by U.S. Public Health Service Grant #1 DO8 PE00402-01*



This paper is a progress report on the department of family and community medicine of the Milton S. Hershey Medical Center, Pennsylvania State University. Dr. Leaman is professor and chairman of the department and director of the family residency program. Drs. Bauer and Wiest are assistant professors in the department. All three authors are certified by the American Board of Family Practice. Dr. Bauer will be assuming a new position as director of the Outer Banks Health Center, Nags Head, North Carolina. Dr. Wiest is director of predoctoral education. Dr. Leaman is a member of the Interspecialty Committee of the Pennsylvania Medical Society.

year he may spend from one to three months with a preceptor.† (One hundred and seven preceptorships have been arranged so far during the current academic year.)

In addition to this teaching, a number of electives are also available. Electives have been offered in normal sexual development, first aid, nutrition, geriatrics, and a clinical clerkship in family medicine. A number of summer projects are available each year in community medicine‡ and/or family medicine. Approximately twelve students participate in this each year.

Residency Program

In July 1971 an approved family practice residency program§ was begun with two residents. Sixteen resident positions are currently approved and filled, with expansion to eighteen positions projected. Each family practice resident is initially assigned a group of families, about twenty-five during the first year, and charged with the responsibility of making every appropriate effort to keep those people well. He serves as their primary physician in all respects. The number of families is increased as his capacity to provide this personalized care grows.

During the first year the resident spends a major portion of his time in a medical rotation and somewhat less in pediatrics. The obstetrics/gynecology rotation is of two months' duration, unless the resident has decided to practice obstetrics when he enters his own practice; he then has the opportunity for extensive training in this area. While there is a two months' rotation in psychiatry, emphasis is placed on the emotional needs of ambulant patients seen over long periods of time. Emphasis in surgery is on initial care of major trauma, minor office-type surgery, surgical diagnosis and complications, with very little operating room experience. Most of the required rotations are completed during the second year. The third year is designed primarily for electives in areas of special interest to the resident or of special need as determined by both the resident and faculty. Approximately one-fourth of the time of the second-year resident is spent in ambulatory care and one-half the time of the third-year resident. Several additional opportunities are available for the resident to be described later under the team teaching and continuing education sections.

Physician's Assistant Programs

In 1968 a pilot program for a "family health advisor" ‖ was started with one nurse, who was given the opportunity to learn a number of special techniques for use in family practice. This person proved quite helpful, and the experience gained is being used in the development of a family health specialist program.¶ In this program, based in the division of nursing of the College of Human Development, Pennsylvania State University, a baccalaureate degree nurse now is able to earn a master's degree as a family health specialist. This person will become an assistant to a primary physician after an eighteen-month training program, part of which will be conducted through this department.

In April of last year a Medex Program # was begun with fifteen students. The purpose of this program is to prepare individuals with extensive training and experience in delivery of patient care as assistants for the primary care physician, particularly those overwhelmed physicians in rural areas. Students receive three months of didactic training at the medical center followed by a year of preceptorship training under a carefully selected physician with whom they will then be expected to continue to work. The fourth class will be admitted in January 1975.

Team Teaching

In order to help various health care providers learn to work together as a team,** two models have been developed to allow them to train together. One model is located in an inner city neighborhood health center and the second in a rural-suburban area. The team consists of a family physician and a neighborhood health worker in the inner-city model to provide continuity, with a rotation of medical students, student nurses, physician assistants, and family practice residents.

Teaching Sites

A rich variety of teaching locales is now available to our students including the two family practice model units at the medical center, university hospital, community hospitals, a neighborhood health center, and the offices of more than fifty practitioners. In addition to these, an ambulatory health care center is being established in a small rural village about thirty-five miles from the medical center. This unit will house several physicians, two dentists, a pharmacy and will provide continuing health care and emergency care to the people of that area. It will be conducted under the auspices of this department as a teaching extension and will have facilities for a rotation of residents, students, student nurses, and physicians' assistants. This will provide a possible prototype for health centers in rural areas for the future.

Continuing Education

Interest of family physicians in continuing education is intense. For three years the department has conducted a course "Newer Concepts of Family Medicine," open to all physicians without registration every Tuesday morning from 8:00 to

† *Supported in part by U.S. Public Health Service Grant # DO8 PE08026-01*

‡ *Supported in part by U.S. Public Health Service Grant # 5A07AH 00285-01*

§ *Supported in part by U.S. Public Health Service Grant #1 D15 PE00076-01*

‖ *Supported by U.S. Public Health Service Grant # % RO1 HS000261-03*

¶ *Supported in part by U.S. Public Health Service Grant # 1D10 NU00855-01*

\# *Supported in part by U.S. Public Health Service Contract # 72-4145*

** *Supported in part by U.S. Public Health Service Grant # 1 DO8 PE00403-01*

9:00 and approved for Category One credit by the American Academy of Family Physicians. In addition, a series of one or two-day seminars is conducted each year on topics of peculiar interest to family physicians.

Research

New disciplines such as family medicine and community medicine need a strong research activity in order to realize their full potential. While our interest in this area is high, we have barely begun to develop this field. A number of our students have done particular research projects in family medicine or community medicine during summers or as part of their research requirement.

A joint project in collection of ambulatory care data is currently being conducted with the family practice program at the Lancaster General Hospital.‡‡ Collection of this data permits quantitative studies of the types of problems seen in family practice, the community relationships, and a comparison between the two family practice departments in varied demographic settings. Information gathered should be of great value in further development of all aspects of the teaching program.

Community Family Medicine

While the programs just described have a great diversity, there are several common purposes which provide a basis for cohesiveness. The first, of course, is the basic interest in teaching family medicine. A second goal of great importance to us as Pennsylvania citizens, and as part of the state university, is the imperative to meet the health care needs of Pennsylvania communities.

Teaching programs stress the community involvement of the family medicine team as a resource for health care information and leadership as well as a provider of health services. Experiences are designed to introduce the student to the community by training him in this setting. Programs are directed to areas of health care need with special emphasis on rural areas.

Rural Health Care

Little reliable documentation is available as to why so few physicians enter rural practice, but most of the physicians of this department have been in private rural practice in Pennsylvania and have a keen awareness both of the problems and of the underlying causes. Among the most important basic reasons why so few physicians enter private rural practice are: (1) inadequate or inappropriate training to meet the challenges of country practice; (2) lack of role models with whom to identify in medical school; (3) lack of familiarity with the advantages and life style of rural communities; (4) lack of appropriate help to provide a share of off-hour coverage and practice "manageability"; and (5) the unavailability of consultation and continuing education.

The entire predoctoral and residency program is, of course, designed to answer the first two identified problems. The preceptorship program has introduction to rural life as one of its major purposes. The Medex program and the family health specialist program are both designed to meet the problems of insufficient properly trained professional assistants.

On the basis of the limited experience we have had so far, we believe that these approaches will provide a substantial answer to the problem of health care in rural Pennsylvania.

Problems

One of the major problems of all family practice programs is in the recruitment of faculty who are both superb family physicians and have an enthusiastic interest in teaching. This problem is extremely critical and will remain so for several more years until graduates of residency programs are more plentiful.

A continuing and difficult problem is evaluation of the results of a teaching program. Much of family medicine involves subtleties of attitude which are difficult to measure or to attribute to a specific learning experience. It is important that we strive to learn such techniques in order to make the necessary curricular changes and devise the best possible teaching mechanisms.

Perhaps as medical educators we should take a more holistic viewpoint in the evaluation of our students. Perhaps we should find ways of measuring total skills, knowledge, and attitudes on a comprehensive rather than on a departmental or disease-centered basis to assess the impact these new physicians will have on the health care in the area where they practice.

Funding of all aspects of the family and community medicine teaching program has been a major problem in the past. Current needs are well met through federal grants, but these are temporary and a sound, permanent base must be developed through state sources. This will require a recognition of commonality of interests of such a program with the need for innovation in the delivery of health care to the citizens of Pennsylvania.

Summary

A brief review has been presented of some of the major areas of involvement of the department of family and community medicine of the Pennsylvania State University College of Medicine as a follow-up to a preliminary report of five years ago. These activities include teaching in both family and community medicine at all levels for medical students, physicians' assistants, family practice residents, and for the practitioner. Health care delivery service to the community is still a large part of the activities and an essential basis for a credible teaching program, we believe. In addition to the medical center, teaching opportunities have been developed in physicians' offices, a neighborhood health center, community hospitals, and are planned for a rural ambulatory care center. A mere beginning has been made in the area of research in ambulatory care. Further details on any of these programs are available. □

‡‡ *Partially funded by a Susquehanna Valley Regional Medical Program Grant*

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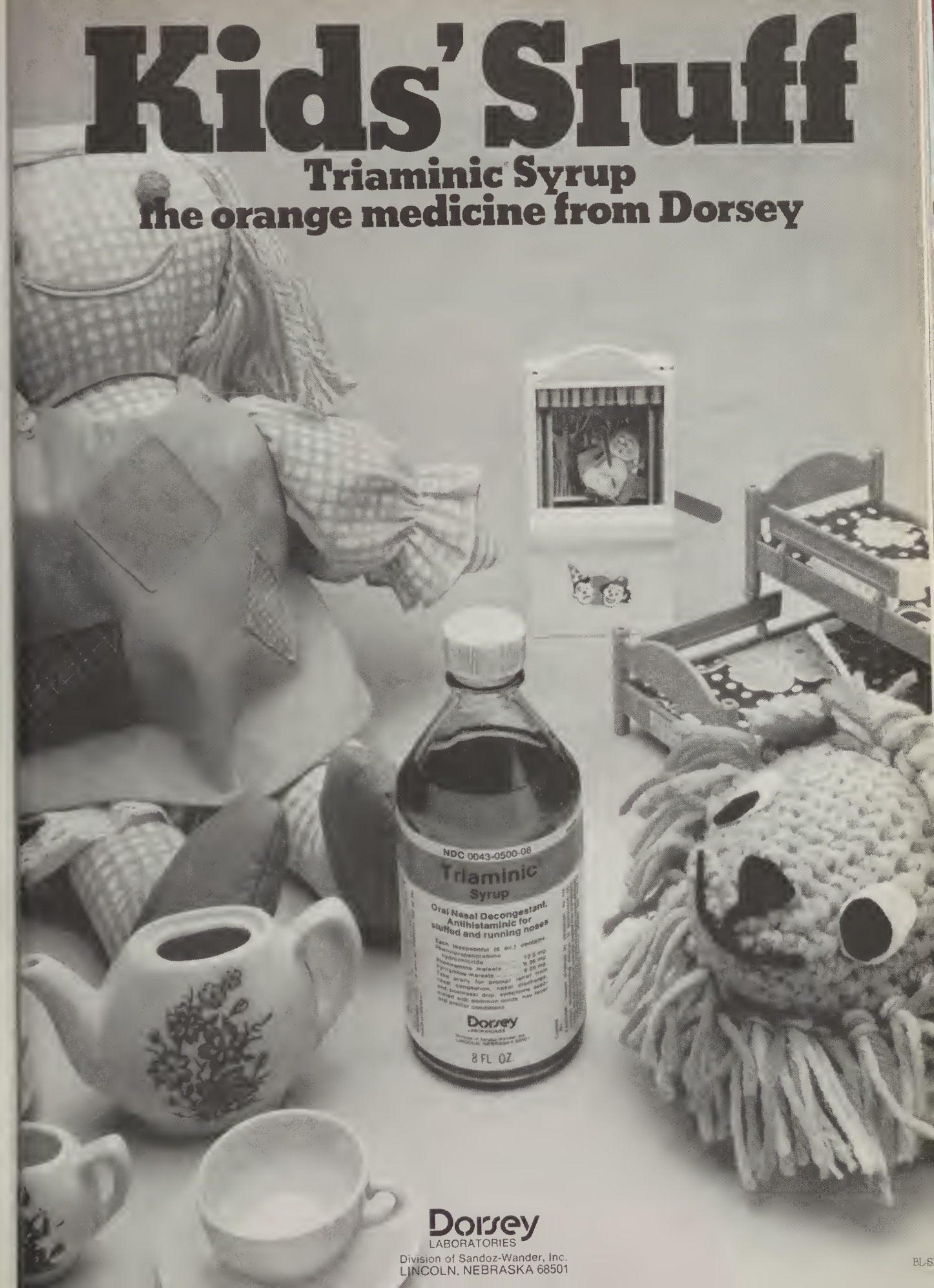

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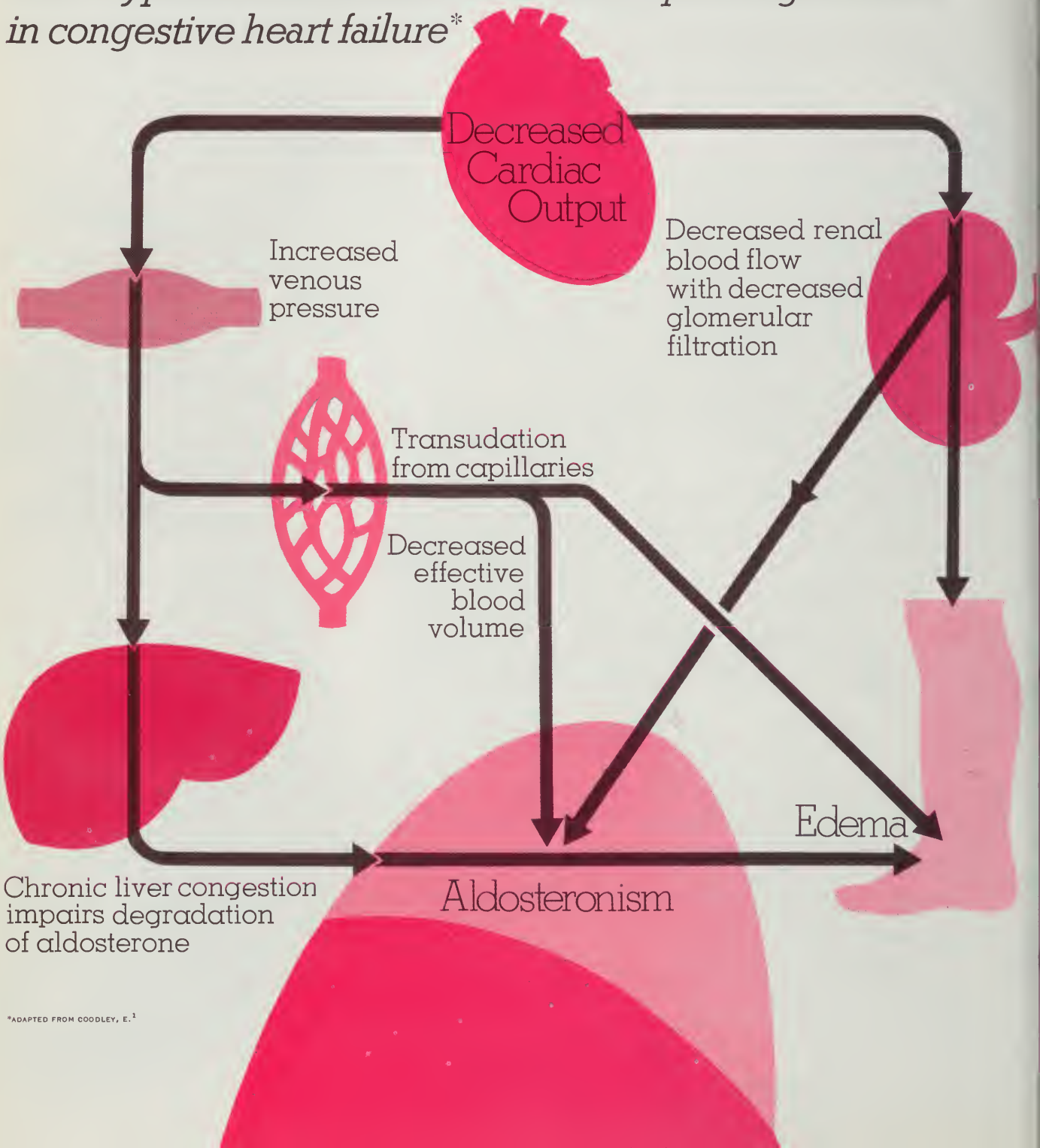

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- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhasis of the liver and the nephratic syndrame; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly pragressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticaid is also given. Discontinue patassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mauth, thirst, lethargy and drawsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blacking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticaid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticaid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannital or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannital is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Caodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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Opinion & Dialogue

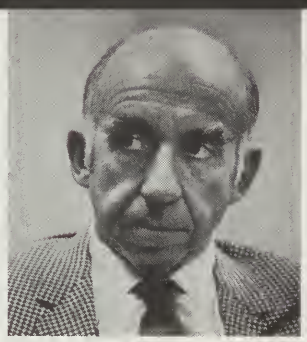
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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Fat embolism

LARRY C. CAREY, M.D.
Pittsburgh

'Our understanding of fat embolism has changed markedly in the past fifteen or twenty years. Few clinical conditions associated with traumatic injury have been more extensively studied in the laboratory or at the bedside. Much remains to be learned, but a major advance has been the identification of the pulmonary functional disturbance as being the major culprit which in turn is responsible for many other system dysfunctions, the central nervous system being the most obvious. The practice of doing blood gas determinations in injured patients has undoubtedly assisted us in recognizing fat embolism early and in subclinical states where hypoxemia may be the only clue to the diagnosis.'

ALL victims of severe trauma are at risk with regard to fat embolism. It is clear that skeletal trauma, while often associated with fat embolism, is not a prerequisite. A primary triad of low arterial pO_2, abnormal chest x-ray, and mental confusion is associated with a secondary triad of petechiae, hypocalcemia, and lipuria to suggest the diagnosis. While fat in the urine and elevated serum lipase are often found in the severely injured, they may occur in the absence of the clinical signs and symptoms of fat embolism. Lipuria was present in forty-nine of fifty severely wounded soldiers and hyperlipasemia in thirty out of fifty. Only five developed the clinical picture of fat emboli.

Several factors appear important in preventing fat embolization. The first is prompt vigorous treatment of shock if it is associated with trauma. Balanced salt solution plus blood is preferred. All fractures should be splinted as quickly as possible and litter transfers held to a minimum. Corticosteroids should be given early and in dose equivalents to 100 mgm of hydrocortisone every six hours for four doses. If arterial pO_2 is below 70, respiratory support should be instituted even in the absence of symptoms of respiratory distress. Finally, once resuscitation is achieved and hemodynamic stability accomplished, fluid should be restricted and diuretics administered in an attempt to diminish lung water.

It is appealing to view fat embolism as a condition similar to aspiration pneumonia except that it begins in the capillary rather than the alveolus. In aspiration, the hydrochloric acid in the alveolae cause interstitial edema and hemorrhage. In fat embolism, neutral fat in the capillary is converted to initiating free fatty acids by lipase in the lung parenchyma, causing interstitial edema and hemorrhage. Steroids are used to attempt to minimize the inflammatory response in both conditions. Heparin has little role in the treatment of fat embolism and has been harmful in experimental settings. Alcohol probably is ineffective since it is nearly always given too late.

Fat embolism is diagnosed clinically and is generally associated with severe trauma and shock. If death occurs, it is most often from progressive pulmonary insufficiency. Prompt treatment of shock, splinting of fractures, and respiratory support are the essentials of therapy. □

Dr. Carey is from the department of surgery at the University of Pittsburgh School of Medicine. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

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Emergency care of the hemophiliac

M. ELAINE EYSTER, M.D.
Hershey

Guidelines for initial therapy are presented and the necessity for appropriate follow-up is stressed

Dr. Eyster is associate professor of medicine and chief of the division of hematology at the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. This is the second in a series of articles on hemophilia.

A KNOWN hemophiliac who presents to the emergency room with symptoms which he attributes to bleeding should be treated as soon as the following questions have been answered. (1) What type of hemophilia do you have? (2) How and when have you been treated in the past? (3) Have you ever had an inhibitor? (4) Where are you bleeding?

Type of Hemophilia

Over 95 percent of hemophiliacs will have either Factor VIII (AHF) or Factor IX (PTC) deficiency. It is important to be certain of the type of factor deficiency before initiating therapy. In the near future, every known hemophiliac in the state of Pennsylvania should have had diagnostic studies at one of the nine state treatment centers and should have in his possession an identification card confirming his diagnosis. (See *Hemophilia and the Pennsylvania Program*, Lewis, J. H. and Gens, R. D., September 1974 PENNSYLVANIA MEDICINE)

Past Treatment

For most hemorrhages, cryoprecipitate or one of the commercial Factor VIII concentrates (Hemophil, ®Hyland; Factorate,® Armour; Humafac,® Parke-Davis; or AHF from Abbott or Squibb) is indicated. Because of the increased risk of hepatitis with concentrates, cryoprecipitate is preferred for the very young child, the mild hemophiliac who bleeds infrequently and has had relatively few transfusions, the adult hemophiliac who has never been jaundiced, and the patient with Von Willebrand's disease. Cryoprecipitate should not be given, however, if the patient has had a previous history of a serious allergic reaction to plasma or cryoprecipitate. None of these products should be used for the patient with Factor IX deficiency since they do not contain significant quantities of this factor. For such patients it is necessary to use fresh frozen plasma or Factor IX concentrates (Konyne,® Cutter; or Proplex, ®Hyland).

Previous Inhibitors

It is estimated that from 5 to 20 percent of patients with hemophilia develop inhibitors which inactivate transfused Factor VIII (or IX). The presence of an inhibitor does not seem to make bleeding episodes any more frequent. However, when bleeding does occur, it may persist longer and be even more damaging because of the lack of response to transfused Factor VIII (or IX). Since transfusions only stimulate the production of more inhibitor, transfusions are *withheld* from patients with inhibitors except under the most urgent circumstances when they are employed with other modalities of therapy by an experienced physician who has the services of an expert coagulation laboratory. Therefore, the patient with a history of an inhibitor should *not* receive treatment with blood products in the emergency room.

Site of Bleeding

Early treatment of hemorrhages before signs become apparent is of great importance. Swelling and limitation of motion are late signs of joint and muscle hemorrhages. Pain or a peculiar burning sensation is often the only early symptom. It should be emphasized that the hemophiliac or his parent is in the best position to tell the physician when treatment is indicated. Moreover, by the time he is seen in the emergency room, it can be assumed that bleeding is significant, and needless delay will only prolong the duration and cost of treatment.

Therapy Recommendations

Both Factor VIII and Factor IX have relatively short half-lives. This means that successive doses must be given if adequate levels are to be maintained. The half-life of transfused Factor VIII (or IX) after the initial infusion is about twelve hours. Therefore, subsequent doses, when indicated, are usually given every twelve to twenty-four hours.

To calculate the number of Factor VIII (or IX units) needed for infusion, multiply the weight of the

individual (in pounds) by the desired factor level (in percent) and divide by 5. For example, to obtain a 50 percent level in a 150 pound individual, $\frac{150 \times 50}{5}$ = 1,500 units. For practical purposes, a single infusion calculated to raise the Factor VIII (or IX) level to 50 percent is usually desirable, since this will provide (1) adequate factor for the initial treatment of a severe hemorrhage and (2) adequate levels long enough after a minor hemorrhage so that subsequent therapy may not be necessary. When commercial fractions are used, dosage calculations are made from units which appear on the product label. Example: Fraction labeled "262 units" = $\frac{1,500}{262}$ = 5.73 bottles. Use instead the full six bottles. If cryoprecipitate is used, one bag is expected to contain approximately 100 AHF units. (e.g. fifteen bags would be required to obtain 1,500 units). When treating a small child, it is advisable to give one or two extra bags to insure adequate coverage.

Cryoprecipitate is stored frozen in individual bags and must be thawed and pooled into a single pack prior to infusion. Both cryoprecipitate and concentrates are usually infused at a rate of 10 to 15ml per minute through a No. 21 or a No. 23 gauge needle. Both may be given directly through an infusion set or IV push from a syringe if care is used to avoid injection of particulate material by using a special filter. When using concentrates, the specific instructions for reconstitution on the package insert should be followed and care taken to administer the entire volume.

Recommendations for specific types of bleeding episodes are as follows: For early treatment of minor spontaneous joint hemorrhages with minimal pain, fresh frozen plasma 10cc/kg is often sufficient. If available, cryo or concentrate may also be given. For more severe hemorrhages into joints or muscles with swelling, severe pain or spasm, cryoprecipitate or concentrate should be given and repeated daily for two to four days.

For gum or lip lacerations, treatment may need to be repeated daily for three to five days. The antifibrinolytic agent epsilon aminocaproic acid (EACA) or Amicar ®Lederle) is frequently helpful in reducing the amount of concentrate required for mouth or dental bleeding. EACA is usually given orally in a dose of 100 mg/kg every six hours for seven to ten days. The total daily dose should not exceed 24 grams. EACA is *not* routinely recommended for other types of bleeding and should not be used in the presence of hematuria.

For grossly bloody urine with pain or clots, a 50 percent initial dose should be given, and fluids should be forced.

Any significant head injury should be treated with at least a single dose of replacement therapy, even in the absence of symptoms. Bleeding into the neck, posterior tongue, throat, or groin necessitates immediate treatment with large amounts of concentrate to bring the calculated plasma level to 50 percent or higher.

Any hemophiliac who has been in an accident should be treated even if no symptoms have appeared when he is seen in the emergency room. Experience has shown that huge hematomas may develop slowly in these patients after severe injury.

The following symptoms are of particular significance:

(1) Any unusual headache, particularly if it persists more than six to eight hours. Nausea and vomiting are late signs of intracranial bleeding.

(2) Numbness, tingling, or weakness of an arm or leg. These symptoms are usually indicative of nerve compression from a hematoma.

(3) Thigh flexion, pain in the hip or back, or urinary frequency. These symptoms are indicative of retroperitoneal or hip bleeding. Numbness or tingling above the patella is an early symptom of femoral nerve compression in association with an iliopsoas hematoma.

(4) Vomiting blood or passing bloody or black stools.

It is most important that the hemophiliac *not* be sent out of the emergency room without adequate follow-up treatment and appropriate diagnostic studies when indicated. In general, these can best be done by a physician who is experienced and knowledgeable in the area of hemophilia. For minor problems, a telephone consultation with such a person may suffice. However, prompt referral to a treatment center is usually indicated since most community hospitals do not stock large quantities of cryoprecipitate or concentrates.

Other recommendations are as follows: Aspirin should never be used in treatment of the hemophiliac since it interferes with platelet aggregation and potentiates bleeding. Plain Darvon® (Eli Lilly & Co.) or acetaminophen should be used instead of aspirin-containing compounds. Intramuscular injections should never be given. Medications should be given orally or intravenously. If given IV, firm pressure should be applied directly to the site for two to three minutes after venipuncture.

Adverse effects of therapy

If the four questions posed previously have been answered correctly, the benefits far outweigh the disadvantages of empiric therapy. The major disadvantages are the risk of hepatitis and the cost. The risk of hepatitis is significant in the mild hemophiliac who is treated infrequently and in the hemophiliac who is given concentrates for the first time. The cost of 1,500 units of Factor VIII is approximately two hundred dollars, and for some patients, the amount of replacement therapy suggested will be excessive. However, for the majority of patients, initial high-dose therapy will achieve prompt hemostasis, and will shorten the duration of therapy required for the enhanced tissue damage which is incurred following inadequate therapy.

Summary

The hemophiliac knows when he is bleeding. By the time he presents in the emergency room, the bleeding episode is usually of sufficient duration and severity to demand prompt treatment with high potency materials. Needless delay will only lead to further complications and additional costs. □

Bladder training in spinal cord injured patients utilizing an intermittent catheterization technique

MAGEE REHABILITATION HOSPITAL
Philadelphia

IN 1970, the U.S. Public Health Service conjectured that there were approximately 100,000 spinal cord injured patients in the U.S. with an estimated annual health care cost of $2.4 billion.[1] Bosch et al state that approximately 4,000 new quadriplegics alone are added to this number each year.[2]

In a study of deaths among paraplegics at the Long Beach Veterans Administration Hospital, 42 percent resulted from renal complications.[1] It is little recognized by the general public (and even by the medical profession not directly involved in the care of spinal cord injured patients) that most such cases permanently lose voluntary control of voiding and that some substitute method must be employed to insure adequate urinary drainage. Unfortunately, many of these methods predispose to urinary tract infection or obstruction and ultimately culminate in renal insufficiency and death.

Most rehabilitation centers and those hospitals interested in spinal cord injured patients are vitally concerned with this problem. The indwelling catheter has for years been the principal stand-by but was attended with complications of infection, periurethral abscess formation, obstruction, and bladder calculus formation.

Many centers have taken advantage of the fact that if the injury were above the sacral segments (and the vast majority are), a simple reflex could be induced, and the bladder would spontaneously empty when triggered or upon becoming sufficiently distended.

A method is proposed to induce such a reflex in male patients employing a technique developed by Lapides known as intermittent catheterization, which was originally designed for patients with atonic bladders.[3] Because this technique does not interfere with the normal rehabilitation program and can be carried on in modified form if the reflex cannot be induced, we believe that it offers considerable advantage over the conventional triggering mechanisms.

Method

1. Patient screening—Patients are briefly screened for candidacy. If it is believed that there are no absolute contraindications, preliminary studies are obtained including complete blood count, blood urea nitrogen, creatinine, intravenous pyelogram and urine culture, antibiotic sensitivity, and colony count. If bladder calculi are encountered, cystolitholapexy is performed. Cystometrograms have been found to be of little prognostic value and are not routinely included.

TABLE I
Bladder Training Utilizing Intermittent Catheterization Technique
Magee Hospital, Philadelphia

Age of Patient	Level of Lesion	†Date of Injury	Date of Admission	ICP Begun	ICP Ended	Status at Discharge
21	C_{5-6}	6/72	9/72 10/73	10/31/73	11/7/73	11/7/73 Voiding spontaneously
21	T-12	10/72	1/73	5/3/73	5/8/73	6/29/73 Voiding spontaneously
# 20	C_{6-7}	9/72	11/72	6/13/73	6/28/73	6/29/73 Voiding spontaneously
19	C_{4-5}	8/72	11/72	3/27/73	4/30/73	9/8/73 Voiding spontaneously
37	C_{5-6}	2/73	5/73	3/73 *	--	9/24/73 with indwelling cath.
21	T_6 & T_{10}	3/73	4/73	6/13/73	8/13/73	11/2/73 Voiding spontaneously
22	C_{6-7}	3/73	5/73	8/9/73	8/23/73	9/28/73 Voiding spontaneously
55	L_1	11/72	2/73	5/1/73	5/30/73	9/8/73 Voiding spontaneously

\# Admitted with suprapubic cystostomy; able to be closed prior to discharge.

† Lapse of time between date of injury and date of admission to rehabilitation center represents stay in acute care facility and/or at home.

* Patient removed from program because of social and language barriers intermittent catheterization started in referring hospital.

2. Sterilization of Urine—Several days before the indwelling catheter is to be removed, an appropriate antibiotic is administered based on the urine culture and antibiotic sensitivity tests and is continued for at least a week after intermittent catheterization is begun to sterilize the urine as completely as possible. Thereafter, a urinary antiseptic is employed until all instrumentation is discontinued. Sterilization of the urine is believed to be a crucial part of the procedure and should not be minimized.

Because frequent urine cultures are expensive and time-consuming, screening "paddle cultures" [4] or stained sediments of urine are employed once or twice weekly to ensure continuity of sterility. If a "positive" screening test is obtained, standard urine culture and antibiotic sensitivity tests are performed, and the patient is retreated. Correlation between the screening procedures and standard culture techniques is very high.[4]

3. Intermittent Catheterization and "Rapid Disconnect" Device—When the indwelling catheter is removed, the patient is fitted with an external sheath and, more recently, a "rapid disconnect" device** which permits catheterization without removing the sheath, thereby eliminating multiple changes and permitting patients to catheterize themselves more readily. Oral fluid intake is reduced, particularly at night, to avoid overdistention of the bladder.

At first, catheterization is carried out by the rehabilitation nurse every four hours, utilizing sterile technique. If the patient voids spontaneously between catheterizations, the urine is collected in a leg bag or bedside bag connected to the external sheath, and the volume measured and recorded before the next catheterization. Volume of urine at each four hour catheterization is also measured and recorded. At the same time, the patient is instructed in self-catheterization and can soon take over the procedure if he has sufficient manual dexterity. In the case of quadriplegics, a responsible member of the family is selected for training.

As spontaneous voiding increases, the length of time between catheterizations is increased, being careful that the volume obtained for each individual catheterization does not exceed 200 ml. Intervals between catheterizations can finally be extended to once every twelve hours and frequently discontinued completely before the patient leaves the hospital; and spontaneous reflex voiding, using one of the commercial external collecting devices, is maintained permanently. Periodic checks of renal function, residual urine, and urine cultures is encouraged.

If no reflex or only a partial reflex can be induced, the patient can be maintained solely on intermittent catheterization or a combination of intermittent catheterization and spontaneous reflex voiding.

Results

Results are summarized in Table I for eight patients. Four more patients are currently on the program. It is to be noted that the time interval between the onset of injury and beginning of intermittent catheterization technique of bladder training is variable and can be successful a year or more after injury.

Discussion

Spinal cord injured patients are generally received directly from acute care units, and rehabilitation procedures are of primary importance. In order not to interfere with programs, it was formerly prudent to delay bladder training until the patient was almost ready for discharge. With the proposed technique, bladder training can be instituted almost immediately since the combination of an external collecting device and intermittent catheterization permits control of urinary output and can be arranged to fit in with the patient's rehabilitation program.

In virtually all cases, male spinal cord injured patients can be discharged free of an indwelling catheter. Only rarely, where the patient cannot be taught self-catheterization and no responsible member of the family is available, is it necessary to resort to surgical bypass procedures or to permanent indwelling catheters.

Although not the ultimate in the solution of the urinary tract problem in male spinal cord injured patients, freedom from an indwelling catheter has provided increased safety and comfort and can permit the induction of spontaneous voiding earlier and without the loss of rehabilitation time.

Summary

A technique is presented using a form of intermittent catheterization through a "rapid-disconnect" device to induce spontaneous voiding in selected male spinal cord injured patients. A pilot program suggests that the method is readily accepted by patients, yields a high rate of success, is simple and economical enough for use by small hospitals, and does not interfere with the rehabilitation time of the patient.

It is believed that the results obtained warrant a full-scale investigation of the program and long-term follow-up to determine its safety and efficiency over an extended period of time. □

The intermittent catheterization program is a team effort by the staff at Magee Rehabilitation Hospital. The pilot project was supervised by Paul Gonick, M. D., associate professor and director of the division of urology, Hahnemann Medical College and Hospital.

** Clinicult Paddle Culture for Bacteriuria, Smith, Kline Diagnostics, Div. of Smith, Kline Corporation, Phila., Pa.*

*** Developed in conjunction with the Franklin Institute Research Labs., Benjamin Franklin Parkway, Phila., Pa.*

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Idiopathic orthostatic hypotension—Shy-Drager variant

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The following case presentation is of the Shy-Drager variant of idiopathic orthostatic hypotension. The clinical presentation, pathology and management are discussed. It is emphasized that supine and standing blood pressures should be recorded in all patients with syncope to insure prompt recognition and treatment of this uncommon entity.

IDIOPATHIC orthostatic hypotension was first recognized as a distinct clinical entity by Bradbury and Eggleston in 1925.[1] It is a rare disorder, and only about 100 cases have been reported.[6] The disease is characterized by orthostatic hypotension, diffuse neurological signs, a slow fixed pulse rate, and a progressive downhill course. Shy and Drager in 1960 further defined the entity and noted Parkinsonian signs, fasciculations, external ocular palsies, iris atrophy, impotence, and urinary and fecal incontinence in their patients. Pathologic studies were included revealing a diffuse degenerative disease of the autonomic nervous system. Reported here is a previously undiagnosed patient who met the clinical criteria set forth by Shy and Drager.[9] His subsequent response to therapy is also reported.

Case Report

C. L., a 49-year-old former maintenance worker, presented at the Allentown Hospital with a three year history of impotence and weakness. Two and a half years prior to admission he developed burning sensation in his lower extremities and urinary incontinence. The incontinence was so severe that it forced him to wear diapers. Urology consultation revealed no urological abnormalities. Over the following two years the patient developed progressive muscular weakness and was forced to stop working. One year prior to admission he noticed "twitching" in the muscles of his upper and lower extremities, decreased perspiration, and unsteadiness in his walking. At this time a myelogram was performed and found to be normal. Five months prior to admission he began having syncopal episodes associated with headache and vertigo; these occurred only while standing. There is no history of dysphagia, dysarthria, tinnitus, fecal incontinence, tremors, diplopia, weight loss, or anorexia. He formerly drank one quart of brandy each weekend for many years. There is no history of syphilis, nor a family history of hypertension or diabetes.

On physical examination the patient appeared middle-aged, was forced to lie supine, and was in no acute distress. The blood pressure was 100/70 in both arms, supine and sitting. Upon standing, no audible nor palpable blood pressure could be obtained, and the patient became dizzy. The change in body position did not alter the pulse rate

which remained regular at 80 beats per minute. The appearance of the iris and lens was normal as was the rectal sphincter tone. Mentation was normal as were the cranial nerves. Vibration, position sense, light touch, pinprick, and stereognosis were normal. Cerebellar tests of finger-to-nose, heel-to-shin, and rapid alternating movements were normally performed. Proximal muscle weakness was apparent in the upper and lower extremities. No fasciculations of the tongue or limb muscles were noted, but mild atrophy of the quadriceps musculature was present. The deep tendon reflexes were active and equal. Unsustained ankle clonus was elicited bilaterally; the jaw jerk was hyperactive. The Babinski response and the Hoffman reflex were negative.

The hemogram, urinalysis, electrolytes, calcium, liver function tests, and fasting blood sugar were normal. Normal roentgen examinations of the chest, skull, and cervical, lumbar, and thoracic spines were obtained. The electrocardiogram and electroencephalogram were normal. The blood volume was measured at 5067 ml/m^2 with a predicted value of 5400 ml/m^2. The cerebral spinal fluid protein was 43 mg/100 cc and its serology negative. Electromyography revealed spontaneous fasciculations in muscle groups of the upper and lower extremities. Peroneal nerve conduction velocity was 50 meters/second (normal). An iodine starch sweat test could not demonstrate sweating.

A clinical diagnosis of idiopathic orthostatic hypotension of Shy-Drager was made. The patient was treated with oral fluid loading, fluorocortisol (Florinef® E. R. Squibb & Sons) and potassium chloride supplements. The Florinef® was gradually increased to 1.0 mg daily. He was fitted with a pair of Jobst leotards. After three weeks of therapy he was able to stand and walk with minimal lightheadedness for the first time in five months.

Discussion

The history of impotence, urinary incontinence, constipation, and progressive muscle weakness; and the findings of orthostatic hypotension, upper and lower motor neuron signs, and absence of sweating substantiates the clinical diagnosis of the Shy-Drager syndrome. The usual age of onset of this disorder is in the fifth to seventh decades, and it has been found more frequently in males.[9] In those cases where autopsied material was available, symmetrical degenerative lesions were noted in the autonomic nervous system including the sympathetic ganglia, intermediolateral cell columns, basal ganglia, medulla, cerebellum, and spinal cord.[6,9,7,3,10]

Various modes of therapy have been advocated for the treatment of idiopathic orthostatic hypotension; these include: elevating the head of the bed, fluid expansion of the intravascular volume, and the use of a waist-high elasticized (Jobst) garment or G-suit. Mineralocorticoids such as fluorocortisol have been employed. Further, a combination of a monoamine oxidase inhibitor (MAO) with tyramine containing foods (cheese and wine), or with sympathomimetics have been used.[4,8,2] Mineralocorticoid therapy is thought to expand the intravascular volume by the retention of sodium. The rationale for the combination of the MAO inhibitor with tyramine or sympathomimetics is to increase the norepinephrine available to the still functioning post-sympathetic nerve endings.[5] These regimens are symptomatic therapy, and the basic progressive neurologic process is not altered.

Many conditions are known to cause secondary hypotension.[11] Idiopathic orthostatic hypotension and the Shy-Drager variant are relatively uncommon medical problems, but prompt diagnosis is important to combat the postural hypotension and resultant syncope which puts the patient in great peril and incapacity. Each patient with syncope, especially with syncope in the upright position, should have supine *and* standing blood pressures measured to search for orthostatic hypotension of any etiology. It is hoped that greater awareness of this syndrome will facilitate prompt diagnosis and treatment.

Summary

A case of the Shy-Drager variant of idiopathic orthostatic hypotension has been presented. The clinical presentation, pathology, and management have been discussed. It has been emphasized that supine and standing blood pressures be recorded in all patients with syncope to insure prompt recognition and treatment of this uncommon entity. □

Dr. Gegwich is senior medical resident and Dr. Campbell is an intern at the Allentown Hospital. Dr. Levitt is a practicing neurologist in Allentown. He was formerly chief resident in neurology at the Peter-Bent Brigham-Beth Israel Children's program in Boston, Massachusetts. *The authors wish to express appreciation to Drs. Jaeger, Tilly, and Stephens of the neurosurgical department, Allentown Hospital, for referral of this patient.*

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Duodenal obstruction in a five-year-old boy

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ACUTE bilious vomiting in a child which is intermittent or persistent may be due to abnormalities in intestinal rotation and fixation. Congenital bands, kinks, and midgut volvulus contribute to the obstructive phenomena, and this is usually manifested in early infancy in approximately 70 to 80 percent of cases.[1,2] In the most common type of malrotation, there is abnormality in fixation and rotation of the duodenum and colon. The cecum is located high in the right upper quadrant, and a dense fibrous band extends from the cecum to the right paravertebral gutter across the descending part of the duodenum.[3] Duodenal obstruction due to incomplete duodenal rotation and with normal colon rotation can occur, but it is rare.[4] This latter condition was seen recently in a five-year-old boy at Memorial Osteopathic Hospital in York, Pennsylvania.

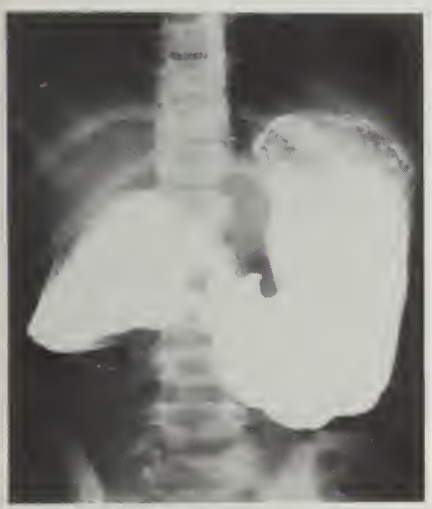

Figure 1. Radiographic study of the upper gastrointestinal tract showing complete "cut off" of contrast at the third portion of the duodenum. There is marked dilatation of the proximal duodenum.

Case Report

A five-year-old white male was admitted to the Memorial Osteopathic Hospital in York, Pennsylvania, on September 22, 1973, because of vomiting of two weeks duration. The vomiting was described initially as occurring mainly after the evening meal. The vomitus consisted of food ingested and had a yellowish tinge. The vomiting became more frequent and projectile and became bilious in character several days prior to admission. He also had recent weight loss. Past medical history revealed that he was a difficult infant to feed and had frequent "wet burps." The subsequent feeding history suggests early satiety, and he was described as a "picky and poor eater." He could not consume a full glass of soda at any given time because of the sensation of fullness and bloating. His weight gain was always poor.

On admission, physical examination was essentially unremarkable except that the patient was asthenic in build and looked slightly dehydrated. The abdomen was flat, and there were no masses, organomegaly, or tenderness. He had normoactive bowel sounds. Radiographic evaluation of the gastrointestinal tract was obtained and revealed almost complete obstruction of the third portion of the duodenum (Figure 1) with dilatation of the proximal duodenum. Later films showed the duodenal-jejunal junction and the proximal jejunum, and the findings were suggestive of abnormal rotation of the third and fourth portions of the duodenum (Figure 2). Delayed films visualized the entire gastrointestinal tract, including the colon, and the cecum was found to be in the normal location in the right lower quadrant of the abdomen. The patient continued to vomit, hence a nasogastric tube was inserted and connected to suction.

On September 28, 1973, laparotomy was performed, and the procedure was described as lysis of adhesions, reduction of jejunal intussusception, and incidental appendectomy. Postoperatively he continued to vomit after the nasogastric tube was removed. At one point he had metabolic alkalosis, which was corrected with appropriate intravenous fluids. Prior to vomiting, he had epigastric fullness and gastric peristaltic waves were seen. A succussion splash was also noted. Repeat radiographic study of the upper gastrointestinal tract revealed exactly the same findings as before the initial surgical intervention. A pediatric surgical consultation was obtained, and after going over the x-rays as well as the physical findings, repeat laparotomy was decided upon.

Figure 2. Thirty minutes later, there is contrast material noted in the proximal jejunum. The duodeno-jejunal junction is notably abnormal in location suggesting abnormality in rotation and fixation.

On October 12, 1973, the patient underwent a second laparotomy, and the findings consisted of incomplete rotation of the duodenum with an adhesive band at the duodenal jejunal junction, medial to the superior mesentery artery. Lysis of this adhesion was accomplished. The duodenal jejunal junction, as well as the first part of the jejunum, was placed vertically into a right gutter. A midgut volvulus of 180 degrees without compromised

Figure 3. Postoperative radiographic study of upper gastrointestinal tract showing free egress of contrast material into the jejunum.

bowel was also noted, and this was reduced without incident. The duodenal jejunal junction and the rest of the small bowel was placed on the right side of the abdominal cavity, and the cecum with the rest of the colon was placed on the left side of the abdominal cavity. In an added maneuver, to maintain the duodenal jejunal junction in a vertical fashion, a nasogastric tube was inserted down to the first portion of the jejunum. On the second postoperative day, the patient was started on oral liquids and tolerated this. The diet was gradually advanced, and there was no further vomiting. Prior to removal of the nasogastric tube, repeat radiographic study of the upper gastrointestinal tract was obtained and showed free egress of contrast material into the GI tract (Figure 3).

The patient was sent home on the sixth postoperative day following the second laparotomy. Since discharge, he has acquired a good appetite and has been gaining weight steadily at a fairly rapid pace. He has not had any vomiting episodes since the last operation.

Discussion

This case shows that patients with an incomplete rotation and fixation of the duodenal jejunal junction may present with subtle symptoms and findings until partial or complete duodenal obstruction occurs. As described in the case report, these patients may have had previous feeding difficulties, including intermittent vomiting, early satiety, bloating, cramps, and poor weight gain.[5] Lewis described four cases of partial duodenal obstruction with incomplete duodenal rotation in the presence of complete colon rotation.[4] Radiographic examination of the upper gastrointestinal tract shows the characteristic dilatation of the proximal duodenum with narrowing and acute angulation of the third and fourth portions. In our patient, the early phase of the radiographic examination showed complete cutoff of the third portion of the duodenum, suggesting an extrinsic obstruction (Figure 1). If no other films had been taken, this would have represented duodenal obstruction by the superior mesenteric artery, as described by Wayne and Burrington.[5,6] The symptoms of superior mesenteric artery compression syndrome is not unlike that of duodenal obstruction due to abnormality of fixation and rotation. The rotation of the intestines about the superior mesenteric artery has been well described by many authors, and the concepts have not changed in the more recent articles.[1,2,3,4,5,7]

In malrotation, the duodenum may be obstructed by bands crossing the duodenum from the incompletely rotated cecum to the inferior surface of the liver or to the posterior portion of the peritoneum.

Dr. Alvear is attending pediatric surgeon at the Polyclinic, Community General Osteopathic, and Harrisburg Hospitals in Harrisburg and at Holy Spirit Hospital in Camp Hill. The author wishes to express his appreciation to Angelo Freda, D. O., and Louis Applebaum, D. O., both of the Memorial Osteopathic Hospital in York, Pennsylvania, for allowing his participation in the care of their patient. He also appreciates the cooperation of the radiology department of the Memorial Osteopathic Hospital for the use of their radiographs for publication.

If the duodenal jejunal loop fails to complete normal rotation, this may become fixed by adhesion in the region of the superior mesenteric artery, and obstruction may be due to torsion, angulation, and kinking. The surgical procedure for patients with abnormalities of rotation of the duodenum consists of freeing the duodenal-jejunal junction as emphasized by Ladd.[7] Careful and meticulous dissection at the duodenal-jejunal junction is followed because of its immediate proximity to the root of the superior mesenteric artery. Placement of a nasogastric tube or long tube beyond the duodenal-jejunal junction and into the jejunum is perhaps an added maneuver to allow straightening of the loop while adhesions are formed postoperatively. The maneuver can also test the patency of the duodenal-jejunal junction in case there is an associated stenosis or web which may not be apparent on gross inspection.

Summary

A case of duodenal obstruction due to an incomplete duodenal rotation with normal colon rotation in a five-year-old child has been presented. The radiographic study is shown as a very helpful means of making a diagnosis. The surgical procedure is described, and an added maneuver to the Ladd's procedure is emphasized. □

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Luke J. Barnett,** Pittsburgh; University of Pittsburgh School of Medicine, 1931; age 68; died July 12, 1974. He was a member of the staff of Mercy Hospital and a member of the Roselia Foundling Association. He is survived by his wife; a son; two daughters; a sister; and two brothers, one of whom is William C. Barnett, M.D., Pittsburgh.

• **Herbert G. Carter,** Pennsburg; Hahnemann Medical College and Hospital, 1931; age 69; died July 15, 1974. He had retired after practicing medicine for forty years. He was a past president of the Homeopathic Association of Pennsylvania. He is survived by his wife, a son, and a brother.

• **Milton A. Chetlin,** Pittsburgh; Columbia University College of Physicians and Surgeons, New York City, 1942; age 54; died July 15, 1974. Dr. Chetlin was assistant clinical professor of the department of surgery at the University of Pittsburgh Medical School. He was a fellow of the American College of Surgeons and of the International College of Surgeons. He was founder and fellow of the American Board of Abdominal Surgery and a diplomate of the National Board of Medical Examiners. He was also a member of the American Fracture Association and the American Geriatric Society. His wife, two daughters, a sister, and five brothers survive him.

• **Joseph N. Corriere,** Bethlehem; Loyola University School of Medicine, Chicago, Ill., 1934; age 67; died July 9, 1974. He was chief surgeon emeritus and former head of the urology department of St. Luke's Hospital. He was a fellow of the American College of Surgeons, the American Urology Association, and a diplomate of the American Board of Urology. He is survived by his wife; two sons, one of whom is Joseph N. Corriere, Jr., M.D., Houston, Tex.; a daughter; two sisters; and a brother, Alexander Corriere, M.D., Carrolton, Ga.

• **Gouverneur V. Emerson,** Milford; Medico-Chirurgical College, Philadelphia, 1914; age 85; died May 16, 1974. No further information is available.

• **Raymond J. Furlong,** Grove City; Temple University School of Medicine, 1939; age 62; died June 13, 1974. He is survived by his wife, two sons, a daughter, and two sisters.

• **William J. Hutchinson,** Simsbury, Conn.; Jefferson Medical College, 1929; age 69; died June 16, 1974. He had practiced medicine in York until his recent retirement. His wife, a daughter, and two brothers survive him.

• **Robert H. Ivy,** Lansdowne; University of Pennsylvania School of Medicine, 1907; age 93; died June 22, 1974. He was emeritus professor of plastic surgery and maxillofacial surgery at the University of Pennsylvania School of Medicine and at the graduate and dental schools. Dr. Ivy was a recipient of the Strittmatter Award of the Philadelphia Medical Society. He was a fellow of the American College of Surgeons, the American Surgical Association, and a past president of the Philadelphia Academy of Surgery. He was one of the founders of the American Board of Plastic Surgery. He is survived by his wife, two sons, and two daughters.

• **Joseph M. Korengo,** Williamsport; Temple University School of Medicine, 1937; age 62; died July 11, 1974. He is survived by his wife, a daughter, and a sister.

• **Michael D. Lauria,** Terre Hill; Jefferson Medical College, 1970; age 30; died June 15, 1974. Survivors include his father, Michael H. Lauria, M.D., Terre Hill; his mother; his wife; a daughter; and a grandmother.

• **Daniel K. Lessig,** Reading; Hahnemann Medical College, 1922; age 76; died July 14, 1974. He had practiced medicine for over fifty years. His wife, a daughter, and three sisters survive him.

• **William A. Messer,** Pittsburgh; University of Pittsburgh School of Medicine, 1932; age 65; died July 24, 1974. He was a fellow of the American College of Surgeons. He is survived by his wife; a son, John B. Messer, M.D., Billings, Montana; a daughter; and a brother.

• **James A. Pabarue,** Erie; Howard University School of Medicine, Washington, D.C., 1951; age 63; died June 26, 1974. He was a fellow of the American College of Surgeons. He is survived by his wife, a son, a daughter, and two brothers.

• **Dominic B. Siberski,** Plymouth; Temple University School of Medicine, 1931; age 69; died July 15, 1974. He is survived by his wife, two sons, two daughters, a sister, and a brother.

• **Louis H. Weiner,** Philadelphia; Temple University School of Medicine, 1925; age 71; died June 24, 1974. He is survived by his wife, a son, two daughters, two sisters, and a brother.

• **Adam C. Williamson,** Ft. Meyers, Florida; Harvard Medical School, Boston, Mass., 1918; age 84; died July 14, 1974. He was a fellow of the American College of Surgeons and the American College of Obstetricians and Gynecologists. He is survived by his wife.

• **Morris B. Weber,** Pittsburgh; University of Pittsburgh School of Medicine, 1922; age 76; died July 29, 1974. He is survived by his wife and three sons, two of whom are physicians; Paul M. Weber, M.D., Oakland Park, Cal., and Murry K. Weber, M.D., Canoga Park, Cal.

William Baurys, Athens; University of Pittsburgh School of Medicine, 1923; age 77; died July 22, 1974. He had been a former chief of urology at the Guthrie Clinic, Robert Packer Hospital, for twenty-six years. Dr. Baurys was a diplomate of the American Board of Urology, a fellow of the American College of Surgeons, and a past president of the Luzerne County Medical Society. His wife and a daughter survive him.

Paul L. Zikoski, Lake Ariel; University of Maryland School of Medicine, 1962; age 42; died June 14, 1974. No further information is available.

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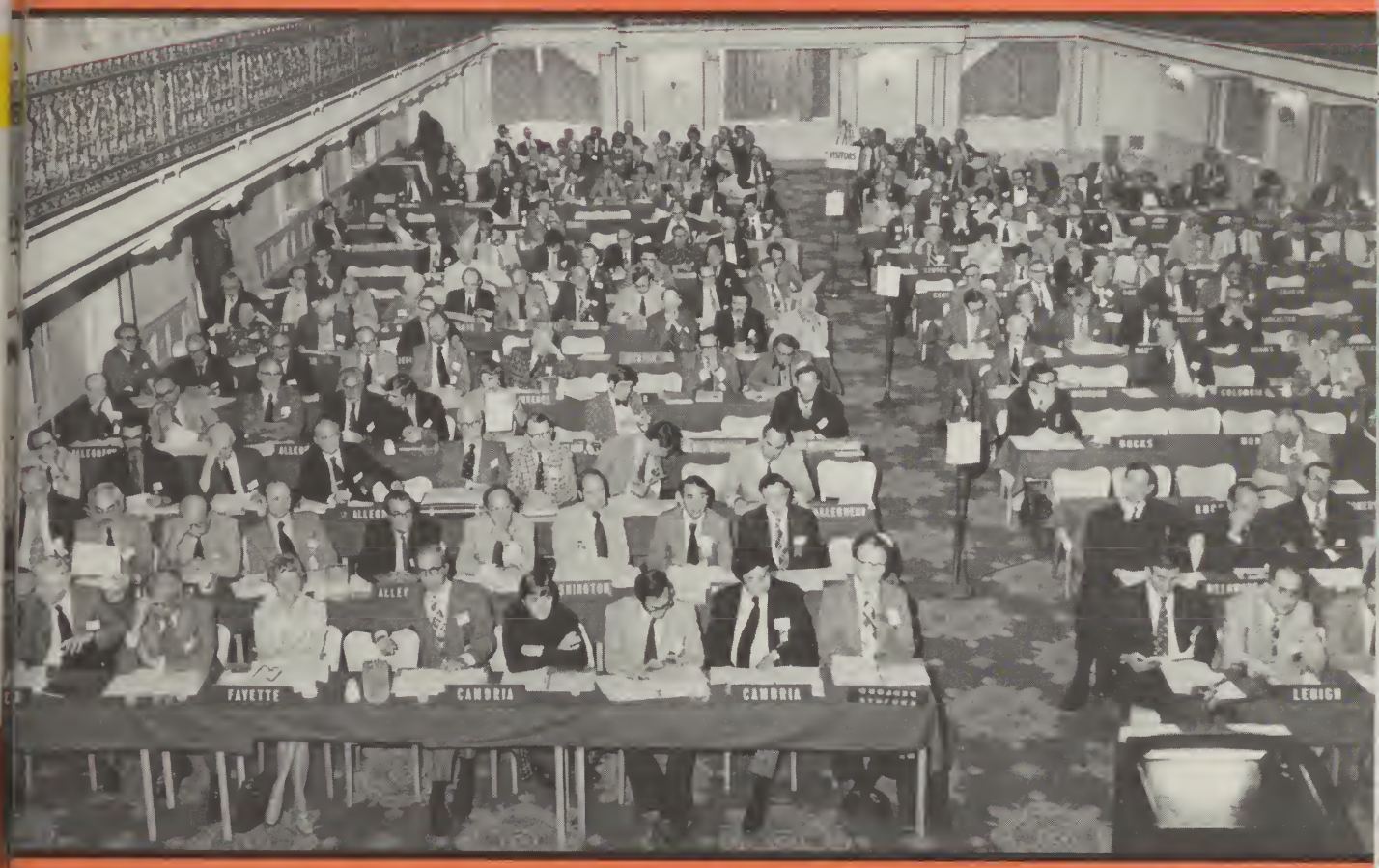

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medigram

November 1974

BOARD MEETS TO IMPLEMENT ACTIONS The Society's Board of Trustees meets November 13 to begin implementation of actions of the House of Delegates, including establishing a "hotline" to the Council on Medical Service to handle Blue Shield and medicare problems and serve as an information source. The resolution calling for the "hotline" also put the Society on record as objecting to confidential nature of the guidelines and criteria for denial of medicare reimbursement by the Department of Health, Education and Welfare, and directed that Pennsylvania's Congressional Delegation be informed of the Society's position in this matter. The recent House of Delegates session was the scene of lengthy discussion of issues in reference committee hearings, at councilor district caucuses, and on the floor. Further news of the session appears elsewhere in this issue.

SOCIETY QUESTIONS LAB REGULATIONS The State Society has sent a formal inquiry to Secretary of Health J. Finton Speller, M.D., questioning the statutory authority for the latest of the regulations proposed by the department under the Clinical Laboratory Act. The proposal would include under the rules "all laboratory facilities operated in private offices and clinics of practitioners of the healing arts except for those issued a 'Certificate of Exemption'." The proposed rule would have physicians seeking an exemption file an application and pay a $25 fee. The Bureau of Laboratories would have the right to determine whether or not physicians' private offices should be exempted. The proposal was published in the Pennsylvania Bulletin October 5, 1974. Interested parties have thirty days to submit written comments. The Society's inquiry was made because the law itself in its definitions seems to exclude physicians' offices and makes no provision for a fee to accompany an application for exemption. In the Act's final regulations published June 15, physicians' private offices were specifically excluded. At the House of Delegates session in Pittsburgh, delegates directed an inquiry into the statutory authority for the rule requiring laboratories to disclose fees charged for tests ordered by physicians on the basis that the rule would cause an increase in costs of tests and could violate confidentiality.

MEDICAL EDUCATION OCTOBER ITEM Directors of medical education from hospitals throughout the state met at the Society's educational assembly in Harrisburg October 23-25. Formation of a permanent organization is a possible outcome of the session. General sessions on acupuncture and long term care and education programs for five state specialty organizations were part of the agenda.

ABORTION CONTROL ACT HEARING DELAYED Pennsylvania's controversial Abortion Control Act (See October Medigram) is in a "state of substantial confusion," the Society's legal counsel has said. The constitutionality of sections

of the Act has been questioned in law suits filed in three federal district courts in Pennsylvania. A hearing on the suit filed in Philadelphia has been postponed until January 15. Meanwhile, enforcement of certain provisions of the Act has been banned by court order. These include the section requiring consent of the spouse or of a parent in the case of a minor; the section subjecting physicians to possible misdemeanor convictions under certain circumstances; and the "viability" section of the law. Society's legal counsel advises: "Until a definitive court decision is made, all physicians performing abortions would be well advised to check with their local legal counsel."

DR. EDMISTON NAMED BY BLUE SHIELD

Robert B. Edmiston, M.D., of Harrisburg, joined the staff of Pennsylvania Blue Shield October 1. He is executive vice president designate for professional relations and will succeed Sidney E. Sinclair, M.D., at the time of his retirement in March 1975. Dr. Edmiston is a diplomate of the American Board of Family Practice and a member of the American Academy of Family Physicians. Dr. Sinclair was cited for his service to the medical profession during his tenure at Blue Shield at the recent session of the State Society's House of Delegates in Pittsburgh.

PAMPAC BOARD ADJUSTS TO INFLATION

Suggested contribution for the Pennsylvania Medical Political Action Committee (PaMPAC) will be $35 a year as a result of action taken by the PaMPAC board of directors when it met in Pittsburgh at the time of the House of Delegates session. The $10 annual increase will bring individual contributions in line with those suggested by political action committees of other state medical societies.

AMA DELEGATION TO PRESENT RESOLUTIONS

The State Society's AMA Delegation will present three resolutions at the meeting of the AMA House of Delegates in Portland, Ore., November 30-December 3, 1974. Presentation of two of the resolutions was mandated by the State Society's House of Delegates. Their titles are: "Medical Audit and Utilization Review Procedures" and "Approval of Present Methods of Quality Control." The third resolution, mandated by the Board, is entitled "Review of Anti-Quackery Activities." The AMA Delegation again held an open hearing at the Annual Session of the House of Delegates and reported on significant actions of the June session of the AMA House. Malcolm W. Miller, M.D., delegation chairman, presided.

BLUE SHIELD PILOT STUDIES CONTINUE

Two Blue Shield experimental programs, a market feasibility study of the Primary Care Program and a test of the concept of fee allowances based on the patient's discharge diagnosis, were reviewed by Robert E. Rinehimer, Blue Shield president, when he testified on the Blue Shield rate increase request at Insurance Department hearings October 15. He said the generally favorable reaction to the primary care program has led Blue Shield to implement the program in the Pittsburgh area, where enrollment of subscribers will begin this month. The study of payment by diagnosis has been expanded to include fifty physicians in five hospitals to permit more definitive conclusions.

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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Charter Membership extended to January 31, 1975

House of Delegates establishes Society policy for 1975

Policy decisions were made and goals established for the State Society as delegates gathered in Pittsburgh in October for the three-day session of the State Society's House of Delegates.

In precedent-setting action, an amendment from the floor increased a proposal for a dues increase from the Finance Committee. Delegates felt a 25 percent dues increase was not sufficient, and therefore raised the dues for 1975 to $150, with an admonition that activity in the field of public communication receive attention and support. The action came at the end of the session and put to rest the fear of deficit spending for 1975.

In accepting a recommendation of the Reference Committee on Constitution and Bylaws, delegates approved a change in the name of the Council on Public Service to the Council on Professional Relations and Services. The Communications Division established by the 1973 House of Delegates received a vote of confidence in the same action.

In a close vote, however, delegates defeated the unified membership proposal of the reference committee. Mandatory AMA membership for State Society members received support from a substantial number of delegates but failed to reach the necessary 75 percent affirmative vote required for change in the Constitution and Bylaws. In a show of hands, 122 delegates voted for, and 65 against, unified membership.

The House reversed a reference committee recommendation by endorsing the approval of the income limits ($6,000 for an individual—$12,000 for a family) for the proposed Blue Shield Plan C fee schedule. The Reference Committee on Medical Service A had recommended disapproval, despite a mail ballot indicating delegate support. The issue was brought before the 1974 House of Delegates because of a poor return of mail ballots. The House of Delegates called for annual adjustments in fees paid and income limits for service benefits tied to the cost of living.

The election of officers saw a contest as H. Thompson Dale, M.D., of State College, and William J. Kelly, M.D., of Pittsburgh, sought the vice presidency and accession to the presidency in 1976, with Dr. Kelly emerging victorious. Complete election results appear elsewhere in this issue.

A. Reynolds Crane, M.D., Society president, was installed at the annual state dinner. His presidential message is on page 18.

Russell B. Roth, M.D., immediate past president of the AMA, became the fifth recipient of the Society's distinguished service award, which was presented at the state dinner. The Society also honored the Woman's Auxiliary to the Pennsylvania Medical Society, which is celebrating its fiftieth anniversary this year. Mrs. Frederick R. Gilmore delivered a report on auxiliary activities to the House of Delegates, and Mrs. Raymond C. Grandon, newly installed as president, received a check from the State Society in honor of the anniversary. The past president's medallion was presented to Mrs. Ralph C. Wilde. Dr. Wilde became Society president at the 1973 session of the House of Delegates and served until his death July 10, 1974.

H. Thompson Dale, M.D., also received honors as he completed his ten years of service on the Society's Board of Trustees. He served the Sixth Councilor District.

Official proceedings of the 125th annual session of the House of Delegates will appear in the December issue of PENNSYLVANIA MEDICINE.

New officers take up State Society duties

William J. Kelly, M.D., Pittsburgh internist, was elected vice president of the Pennsylvania Medical Society during the 125th Annual Session of the House of Delegates last month in Pittsburgh. In accordance with the Constitution and Bylaws he will succeed to the presidency elect in 1975 and become Society president in 1976. At the meeting A. Reynolds Crane, M.D., of Philadelphia, was formally installed as Society president; and David S. Masland, M.D., Carlisle, moved automatically from the vice presidency to the post of president elect.

DR. KELLY

Dr. Kelly has served as trustee and councilor from the Tenth District on the Society's Board of Trustees, is a past president of the Allegheny County Medical Society and the Pennsylvania Society of Internal Medicine, and is currently vice chairman of the State Board of Medical Education and Licensure.

G. Winfield Yarnell, M.D., Harrisburg, was elected Society secretary; and John B. Lovette, M.D., of Johnstown, and D. Ernest Witt, M.D., of Bloomsburg, were re-elected speaker and vice speaker of the House of Delegates respectively.

Donald R. Cooper, M.D., of Philadelphia, was re-elected to the Board of Trustees to represent the First District. Joseph M. Stowell, M.D., of Altoona, was elected to succeed the retiring H. Thompson Dale, M.D., as trustee and councilor from the Sixth District; and David W. Clare, M.D., of Pittsburgh, was elected to fill the post of trustee from the Tenth District which became vacant on the election of Dr. Kelly as vice president. Lewis T. Buckman, M.D., of Wilkes-Barre, was re-elected to the Society's Judicial Council.

Six delegates to the American Medical Association were elected at the Annual Session. They are Drs. R. William Alexander, Reading; Raymond C. Grandon, Harrisburg; Edmund L. Housel, Philadelphia; William J. Kelly, Pittsburgh; William Y. Rial, Swarthmore; and George A. Rowland, Millville.

JOHN RINEMAN, DR. CRANE

Elected as alternate delegates to the AMA were: Drs. Harry V. Armitage, Chester; Robert J. Carroll, Pittsburgh; James B. Donaldson, Philadelphia; H. Robert Davis, Boiling Springs; Loraine H. Erhard, Clearfield; Lawrence D. Ellis, Pittsburgh; Richard L. Huber, Scranton; and R. Robert Tyson, Philadelphia.

Following the final session of the House of Delegates, the Board of Trustees met to reorganize and re-elected Cyrus B. Slease, M.D. as chairman. George A. Rowland, M.D., was elected vice chairman. The Board re-elected the following: John F. Rineman, executive vice president and treasurer; David A. Smith, M.D., of Harrisburg, medical editor of PENNSYLVANIA MEDICINE; and Pepper, Hamilton and Scheetz, legal counsel. William J. Ryan, M.D., of Somerset, was re-elected as Board representative to the Pennsylvania Medical Care Foundation. Robert S. Sanford, M.D., immediate past president, was elected by his fellow Board members to retain his seat as a voting member of the Board for another year to complete the membership of the Board of Trustees.

DR. MASLAND

State Society launches drive for new members

Six thousand nonmember physicians will receive a letter from the Society this month (November) asking them to join organized medicine. The letter from Society President A. Reynolds Crane, M.D., begins a recruiting campaign directed by the Advisory Committee on Membership of the Society's Council on Professional Relations and Services.

Targets of the November recruitment drive are 3,000 interns and residents and 3,000 other physicians in the Commonwealth who, according to AMA master computer tapes, do not now belong to organized medicine.

Robert Poole, III, M.D., Chester County, chairman of the advisory committee, reports that the 6,000 prospects will receive an individually typed letter, a list of 1974 Society activities, and a new "Services and Functions" pamphlet containing a thumbnail sketch of the Society. The pamphlets contain a tear-out reply card. Membership chairmen and secretaries of county societies will receive a carbon copy of the letters for use in personal follow-up. Additional recruiting materials are available from L. Riegel Haas of the State Society staff.

To date, membership statistics show a general rise over the past four years. Last year for the first time in the Society's history, membership passed the 13,000 mark, and this year at the end of September membership totaled 13,194. Senior active membership (physicians 65 years of age and over) has expanded from 624 in 1971 to 893 in September of 1974. In terms of percentages, the greatest growth is in the interns and residents category, with more than a 100 percent increase. Numerically, interns and residents still constitute only a small part of PMS membership (422).

American Medical Society (AMA) active membership, which had dropped off in 1971, 1972, and 1973, is on the upswing this year. Total AMA membership from Pennsylvania in September was 10,235, representing an increase of 200 over 1973.

Telescopic lenses bar to driving

John W. Robertson, Jr., M.D., chairman of the State Board of Medical Education and Licensure, has made public a letter verifying that visual standards adopted by the Bureau of Traffic Safety of the Department of Transportation **do not permit** anyone requiring telescopic lenses to operate a motor vehicle.

The letter, signed by Julius A. Trombetta, director of the bureau, resulted from an inquiry made to the state board, which requested that the information be publicized in PENNSYLVANIA MEDICINE because, according to the original letter of inquiry, reports have been published that sixteen states permit use of such lenses. Pennsylvania is not one of them.

State lists drugs optometrists may use

Final approval has been given by the Pennsylvania Department of Health for the use of certain drugs by qualified optometrists.

Local anesthetics approved are benoxinate hydrochloride—ophthalmic solution (0.4 percent) and proparacaine hydrochloride—ophthalmic solution (0.5 percent). The miotic approved is pilocarpine nitrate ophthalmic solution U.S.P. (1 percent). Mydriatics and/or cycloplegics include eucatropine hydrochloride U.S.P.—ophthalmic solution (5 percent), tropicamide ophthalmic solution U.S.P. (1 percent), homatropine hydrobromide ophthalmic solution U.S.P. (2 percent), and hydroxyamphetamine hydrobromide ophthalmic solution U.S.P. (½ percent).

It should be noted that the maximum potency for the last two drugs listed was reduced from that proposed. In all cases the potencies listed are the maximum allowable potencies under the new regulations.

J. Finton Speller, M.D., secretary of health, has reported that further study and analysis is necessary before listing eight additional drugs which had been proposed in the *Pennsylvania Bulletin* dated July 6, 1974.

Heart association honors physicians

Physicians and the Pennsylvania Medical Society were honored by the American Heart Association, Pennsylvania Affiliate, during its twenty-fifth annual Assembly, held September 21 in Harrisburg.

A. Reynolds Crane, M.D., Society president, accepted the Special Recognition Award which cites the occasion of the Affiliate's twenty-fifth anniversary and expresses "deep appreciation for the individual contributions of physicians throughout Pennsylvania, and the long-standing cooperative relationship between our organizations."

Co-op start approved without further Society funding

The Pennsylvania Medical Co-operative has been authorized to extend its charter membership campaign to January 31, 1975 and to become operable as soon as possible, but without financial assistance from the State Society.

Such was the action of the House of Delegates at its meeting in Pittsburgh last month. As a result the Council on Professional Relations and Services will concentrate on recruiting more members so that the operational phase may be initiated as soon as possible. Studies have shown that $200,000 is necessary to begin operating the mass purchasing plan. An analysis of the charter membership indicates that the nearly 1,300 charter members actually represent more than 2,000 buyers because of partnership and groups. The council's continuing recruiting campaign will concentrate on full membership in the cooperative from all members of group practices and on carrying the message of the cooperative to those areas in the Commonwealth where physicians have not yet been contacted personally.

The Board of Trustees had proposed that the Society invest at interest the necessary funds for immediate implementation of the mass purchasing plan. Although the Reference Committee on Public Service recommended approval of the Board's proposal, delegates judged that the cooperative should become operational independent of further direct financial support from the Society.

DELEGATES CAUCUS IN COUNCILOR DISTRICT MEETINGS

Education requirement for PMS membership clarified

Membership in the Pennsylvania Medical Society will require showing of evidence of participation in continuing medical education activities as of December 31, 1975.

The membership requirement was clarified by action taken at the 1974 session of the Society's House of Delegates. Delegates voted in favor of an amendment to the Bylaws clarifying that association members must meet the education requirement. Associate members no longer in active practice will be granted a waiver.

Delegates also approved a recommendation that the final date for *reporting* education activities be extended from December 31, 1975 to June 30, 1976. Credits must be earned, however, by June 30, 1975, if they are to be applied to the membership requirement and the 1975 AMA Physician's Recognition Award.

REFERENCE COMMITTEE ON EDUCATION AND SCIENCE

Those wishing to apply for a waiver from the education requirement may do so by contacting the Commission on Accreditation. Appeals from the commission's decision will be decided by the Society's Board of Trustees.

Delegates approved a recommendation from the Reference Committee on Education and Science that the Commission on Accreditation, "during the difficult initial qualifying period . . . offer all possible assistance to those physicians encountering difficulty in meeting the requirement."

Foundation support renewed

The Pennsylvania Medical Care Foundation corporation members met during the Annual Session of the House of Delegates in Pittsburgh to consider the annual report of its board of directors and elect members of the board.

Bylaws changes and one deletion from the Articles of Incorporation recommended by the board of directors were approved. The reports of Foundation President Matthew Marshall, Jr., M.D. and of the board of directors were reviewed by delegates who approved the Foundation's activities as having "effectively carried out the directives of the House of Delegates."

Delegates directed the Foundation to continue its efforts to assist in Professional Standards Review Organization implementation in Pennsylvania and to continue other activities and programs to accomplish the objectives of the Society as established by the House of Delegates, with direction to come from the Society's Board of Trustees.

Foundation corporate members elected seven members to the board of directors: Joseph N. Demko, M.D.; Henry H. Fetterman, M.D., Matthew Marshall, Jr., M.D., William B. McNamee, M.D.; George R. Moffitt, Jr., M.D., Raymond J. Saloom, D.O.; and Donald C. Brown, M.D., of Greensburg, who is a new board member.

The Foundation's annual report appears on page 66 of this issue of PENNSYLVANIA MEDICINE.

AMA DELEGATES AT OPEN HEARING DURING ANNUAL SESSION

Initial results of Blue Shield physician survey revealed

Results of a survey to determine the opinions of Pennsylvania physicians on Blue Shield's administrative performance in business operations and as a carrier for Medicare Part B are being tabulated by Pennsylvania Blue Shield's research department and an outside professional research consulting firm.

Questionnaires were sent this summer to 3,305 physicians, both participating and nonparticipating, separated into representative segments by degree, specialty, and geographic location. Of the 1,123 replies, 85.6 percent were from doctors of medicine, 8.5 percent doctors of osteopathy, and 5 percent doctors of podiatry or surgical chiropody. A follow-up telephone survey to a representative sample of nonresponding physicians revealed no significant differences of opinion.

Family physicians and internists comprised 39.9 percent of the replies, surgeons 13.8 percent, and other specialties 53.7 percent. Geographically 43.5 percent were from Philadelphia and the eastern district, 26.7 percent from Pittsburgh and the western district, and 26.9 percent from central and northeastern Pennsylvania.

Overall, 70 percent of doctors of medicine and doctors of osteopathy indicated general satisfaction with Blue Shield's regular business operations in such areas as claims processing and general policies. Doctors of podiatry indicated 90 percent satisfaction.

General and family practitioners were the most satisfied with administrative performance, with specialists and surgeons the least satisfied. Physicians under 45 years of age indicated the least satisfaction, older physicians the highest. Younger physicians complained of specific areas in the handling of inquiries, promptness of replies, and claims processing. A higher percentage of physicians in the Philadelphia district encountered problems with claims processing and general service and regarded prevailing fee payment levels as inadequate.

Replying to questions on specific plans, 67 percent indicated satisfaction with Medicare Part B. Questions on prevailing fee levels elicited the following responses: 20 percent of doctors of medicine regarded payments as much too little, 40 percent as too little but acceptable, and 35 percent as appropriate; doctors of osteopathy 15 percent much too little, 42 percent too little but acceptable, and 36 percent appropriate; doctors of podiatry 4 percent much too little, 36 percent too little but acceptable, and 55 percent appropriate. Neither specialty nor age group affected these figures, but 24 percent of Philadelphia district physicians indicated dissatisfaction. Over 50 percent of all physicians were dissatisfied with Plan B payouts.

In specific service areas, 74 percent of all groups replied that the handling of their inquiries and correspondence was satisfactory; 61 percent indicated prompt handling. Twice as much dissatisfaction was reported in the age group between 25 and 34 as in physicians 65 and older.

Overall, surgeons and specialists reported the greatest degree of dissatisfaction. Incorrect coding, interpretation, and impersonal processing and review were the most frequent complaints.

The section of the survey requesting suggestions for improvement revealed that 33 percent of physicians polled wanted increases in payment levels; 25 percent suggested improved communications (both between physicians and Blue Shield and in the area of better education of patients regarding their coverage); and 14 percent felt that improved coverage, particularly in the specialties, is needed.

Additional suggestions were that physicians should be more fully informed of policy changes; that a flexible fee schedule tied to the cost of living index would be an improvement; that more involvement by physicians in policy decisions is needed; and that simplification of services could be instituted.

Louis A. Persic, M.D., of St. Marys (center), secretary of the Elk-Cameron County Medical Society, learns more about Society activities from Robert H. Craig, Jr. (left), director of governmental relations, and John F. Rineman, PMS executive vice president, at a recent orientation visit to State Society headquarters.

HMO action, reaction in Commonwealth reported

Health Maintenance Organizations (HMOs) in Pennsylvania are not springing up like Topsy since the passage of Act 364, the Health Maintenance Organization Act of 1973 (see PENNSYLVANIA MEDICINE, April 1974, page 12). In this area, the Commonwealth is no different from the rest of the nation, where HMO activity is moving slowly.

Insurance Commissioner William J. Sheppard has announced the approval to operate a health maintenance organization (HMO) to the Metropolitan Life Insurance Co. It will be located in downtown Pittsburgh in the new Central Medical Pavilion, a $21 million facility including a 242-bed hospital and office space for fifty-one physicians. The HMO, the Metropolitan Central Medical Option, expects to serve 10,000 individuals by the end of one year, with a possible 50,000 participants who are group policyholders of Metropolitan health insurance policies. It is the first operational HMO in the Pittsburgh area, and seventh to be licensed in the state.

The Central Medical Pavilion which houses it was developed largely by Metropolitan, which is also the mortgage holder.

Pittsburgh HMO Developing

The Community Health Association of Western Pennsylvania, Inc. (CHA), a nonprofit professional corporation which is developing an HMO, has entered into an agreement of affiliation with Montefiore Hospital in Pittsburgh.

Named the Penn Group Health Plan, Inc., services will include physicians, hospital, laboratory, emergency, preventive, and other health services.

Part of the group will be located at Montefiore, with a major ambulatory facility in Monroeville and a third center at Western Pennsylvania Hospital.

Funding for the group has been received from the U.S. Department of Health, Education, and Welfare and from private contributors. The initial enrollment target is 17,000 from the eastern quadrant of Allegheny County.

Philadelphia HMO Moves

Eighth and Spruce Medical Associates, an HMO group practice unit organized at Pennsylvania Hospital, Philadelphia, has announced plans to move into renovated facilities this fall. The new location is on the ninth floor of the Spruce Building and has been designed to accomodate patients in specially designed waiting and examining rooms. A nursery for young patients and children of patients has been provided.

Foundation for Lehigh County

In Lehigh County, the medical society and the Lehigh Valley Osteopathic Association have moved to form a foundation for medical care and "to encourage participation of those counties in PSRO Area IV—the foundation's purpose being to offer positive alternatives to closed panel (HMO) medical care."

Members of the Lehigh Valley Medical Society approved a special assessment of $50 on each full dues-paying member to finance the foundation, which would provide an alternative to closed-panel group practices but still offer a prepaid comprehensive health plan to patients.

At a special meeting in July, members heard Herbert Strohson, executive vice president of Uni-Med Services, of Denver, Colo., outline the goals and benefits of closed panel prepaid groups (HMOs) and open panel groups (foundations).

He said that the advantages of the closed panel system include "optimum utilization of the physician's time, facilities, and equipment; opportunity for internal education of professional and patient; a greater reliability of service; and a systematic approach to medical care delivery."

He cited as disadvantages loss of physician control, inflexibility, lack of individual incentives, and the geographic limitations imposed by a confined organization and a narrow choice of doctor and facility by the patient.

Strohson said the best of both worlds can be found in the open panel foundation, which applies the efficiencies and disciplines of the closed panel without limiting freedom of choice.

Other county medical societies in PSRO Area IV (Wayne, Monroe, Northampton, Pike, and Carbon) are studying the foundation concept, and in Lehigh County, the Health and Hospital Council has studied the feasibility of a closed panel HMO. It found that an HMO is not feasible at this time, but has recommended that the possibility be reviewed within two years. It suggested in the meantime that consumers, businessmen, labor organizations, and insurance carriers join to aid the foundation's formation and development.

The framework for the foundation is built by the county medical societies and osteopathic associations. The foundation is a nonprofit organization to provide care for patients who have group health protection. The health care contracts must provide benefits which meet certain minimum standards of coverage established by physicians. Em-

phasis is on outpatient care. Physicians joining the foundation agree to accept reimbursement from the insurers through the foundation as payment in full and agree further to ongoing peer review.

The development of the Lehigh County foundation is continuing under the direction of the Founding Committee, and the ad hoc study committee has been dissolved.

In September, however, the Northampton County Medical Society tabled plans for participating in a foundation pending further study. The Carbon County Medical Society endorsed participation in principle.

Elsewhere in the state, the Delaware County Medical Society has appointed two members, Samuel D. Allen, M.D., and E. Earle Trout, M.D., to serve on the Delaware County Alternative Delivery System Committee, which consists of industry, provider, and consumer members. This committee is conducting an alternative delivery system study through the AHMAC Corporation, an Ardmore health management and consulting firm. Delaware County employers have provided funds for the study.

Trust reports to House of Delegates

The 1973 annual report of the Educational and Scientific Trust of the Pennsylvania Medical Society reveals that applicants for medical student loans rose 30 percent, principally due to an increase in the cost of medical school tuitions and living expenses and to an increase in the number of students enrolled.

The trust reported to the 1974 House of Delegates that the cost of a medical education has increased to the extent that a first-year medical student will expend between $5,600 and $7,900 for the year.

A new group life insurance policy has been purchased as surety in the event of the death of debtors prior to repayment. According to Alex H. Stewart, executive director and secretary of the trust, the $4,000 premium will be paid for on a prorated basis out of earned income by each of the fifteen funds having loan programs.

Assets for the trust amounted to $1,616,786, which included outstanding loans of $1,131,959 to over 750 borrowers. During the year, the Committee on Aid to Education and the trustees of the trust allocated $171,315 in new loans to 236 students. Contributions of $86,640 came from Pennsylvania Medical Society members and $93,684 from other individuals, organizations, and auxiliaries.

The newest fund was created by a donation from Dorothy B. Goodman in the amount of $25,000 in memory of her uncle, Lewis H. Bacon, M.D., formerly of Pottsville, to be used for Schuylkill County residents.

WORKING TOGETHER in areas of mutual concern was the purpose of a joint meeting of the executive committees of the State Society and the Hospital Association of Pennsylvania (HAP) held at PMS headquarters recently. A joint committee was proposed to analyze hospital control legislation, to draft a statement on malpractice insurance as a prerequisite to hospital staff admission, and to prepare an explanation of the "due process" procedure regarding medical staff appointments as outlined in standards of the Joint Commission on Accreditation of Hospitals. Attending the meeting and shown above, left to right, are: Seated—H. Thompson Dale, M.D., PMS; James R. Neely, HAP; A. Reynolds Crane, M.D., PMS; Cyrus B. Slease, M.D., PMS; Ben Badman, Jr., HAP; John F. Rineman, PMS; George A. Rowland, M.D., PMS; and standing—Fred Speaker, PMS; Norman Skillman, HAP; James H. Stewart, HAP; David S. Masland, M.D., PMS; Robert S. Sanford, M.D., PMS; John F. Wicks, HAP; Robert H. Craig, Jr., PMS; and Thomas S. Powell, HAP. Drs. Masland and Rowland will represent the State Society on the joint committee.

editorials

Education requirement questions answered

Continuing medical education has always been an important part of the physician's professional life and as such has been pursued by most in the attempt to provide better medical care. Karl Marx pointed out that "The education of most people ends upon graduation; that of the physician means a lifetime of incessant study." Within the last five years, the spotlight has been turned on this aspect of the physician's career and he must now show written proof of his postgraduate training. For those who consistently strive to improve themselves through education, this task should be of little consequence.

The American Medical Association House of Delegates established the Physician's Recognition Award (PRA) in December 1968 on a voluntary basis. It was not until October of 1971 that the Pennsylvania Medical Society made this a requirement for membership in the State Society. By June 30, 1975, all physicians in Pennsylvania who wish to maintain their membership in the medical Society must have qualified for the award. Failure to qualify will result in suspension of membership, but by action of the House of Delegates last month, members will have until June 30, 1976 to submit their PRA applications to the AMA.

Some physicians have elected to apply for the 1974 Physician's Recognition Award, many for the first time. Legitimate questions have arisen concerning the compilation of data for the form and are worthy of discussion. One of the most common deals with the definition of what constitutes a Category I continuing education activity as opposed to a Category II program. Basically, they are the same, differing only in the type of sponsorship. Category I programs are planned continuing medical education activities with accredited sponsorship, while Category II programs are sponsored by nonaccredited organizations. Both may have equal planning, administration, evaluation, and course content, but only those with accredited sponsors are acceptable in Category I. AMA accredited institutions are listed in the booklet accompanying the award application, and the Pennsylvania Medical Society periodically publishes the names of accredited institutions in PENNSYLVANIA MEDICINE.

Courses listed in the August supplement of JAMA and the September supplement of PENNSYLVANIA MEDICINE are Category I accredited programs. A course that has an accredited sponsor or cosponsor, but which is not listed in either of the above cited sources, is acceptable for Category I credit. Not all course information reaches the editorial staff in time to be included in these publications, so even if you cannot verify it, include it.

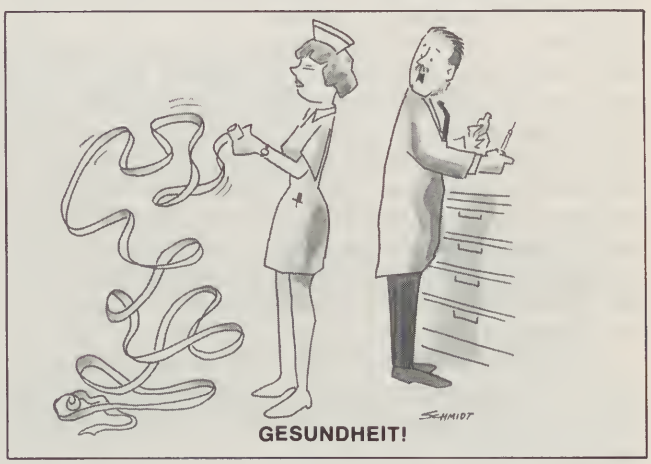
Increased use of audiovisual materials such as videotapes, films, and audiotapes has created new learning experiences for physicians and are within the definition of planned programs. Those materials that are used by groups of physicians, comply with the planned program criteria, and have accredited sponsorship, should be applied to Category I. Individual use of audiovisual materials or nonsupervised use falls within Category V, self-learning.

PSRO, medical audit and other peer review activities are learning experiences and are allowable for credit in Category V, patient care review. Emphasis on this aspect of medicine in the coming years will easily afford physicians an opportunity for twenty-two hours of credit.

Other meritorious learning experiences, Category VI, is a catchall for activities which do not easily lend themselves to inclusion in any of the other areas. In answer to a question recently received, this, unfortunately, does not include time spent reading *Playboy*.

Additional information concerning the Physician's Recognition Award or continuing medical education may be obtained from the Council on Education and Science of the Pennsylvania Medical Society.

David A. Smith, M.D.
Medical Editor



GESUNDHEIT!

Dr. Crane addresses House of Delegates

A. Reynolds Crane, M.D., president of the Pennsylvania Medical Society delivered this message to the 125th Annual Session of the Pennsylvania Medical Society on Thursday, October 10, 1974 at the William Penn Hotel, Pittsburgh. His address served two purposes, because he spoke both as Society president and president elect. His term of office began early when he automatically succeeded to the presidency on July 10, when death took Ralph C. Wilde, M.D.

Having taken the helm in mid-stream, as it were, I find myself a little uncertain as to whether the correct role at this time is to report on the accomplishments of the past year as President or to trace pathways through the future as president elect. Looking backward I would, first of all, pay tribute to my able and respected predecessor, Dr. Ralph C. Wilde. I knew him only for the brief time he served as president elect and president but in that short period came to admire him greatly for his ability as a quiet and effective leader with a keen insight and quick understanding of the problems before him. His courage and stamina were never better evident than in the clear and concise summary he gave of the two-day Officers' Conference in April, despite the debilitating effects of the leukemia which was to take him from our ranks too soon. We do—and shall—miss him sorely. The passing of the gavel occurred smoothly because of his leadership and the very fine work that had been done for him and under him by all of you and our colleagues serving on the various councils and commissions, by the Woman's Auxiliary, and by our very effective and exceptionally competent administrative staff. To all of you I would express appreciation in his name, as well as my own, and in so doing pay tribute to his memory and his contributions to this Society.

The challenges and accomplishments of the past year are well covered in the reports of the Board of Trustees and Councilors, the standing committees, the councils and commissions, and the Woman's Auxiliary, all of which are contained in your official reports book and need no embellishment from me. They well attest to the vigor and vitality of your Society and its ability to address the many challenges constantly appearing on the medical scene, as well as the will to initiate new concepts and approaches to all aspects of patient care and the public health. Adaptability is the basic strength of a useful and productive organization and as you read the reports you will readily identify this capability in your Society.

I have neither a crystal ball nor the prescience of the saints. The fact that I walked the pathways of the great philosophers as an undergraduate at college, saw the growth of social planning as a young man and, as a physician, witnessed the incredible developments of medical science has not placed in my hands the talent to outline the future any more than it has put it in the hands of any of you. However, the office of the president permits, indeed demands, a description of the effects of the convergence of these streams upon society, that you may use the strands to weave the structure of tomorrow.

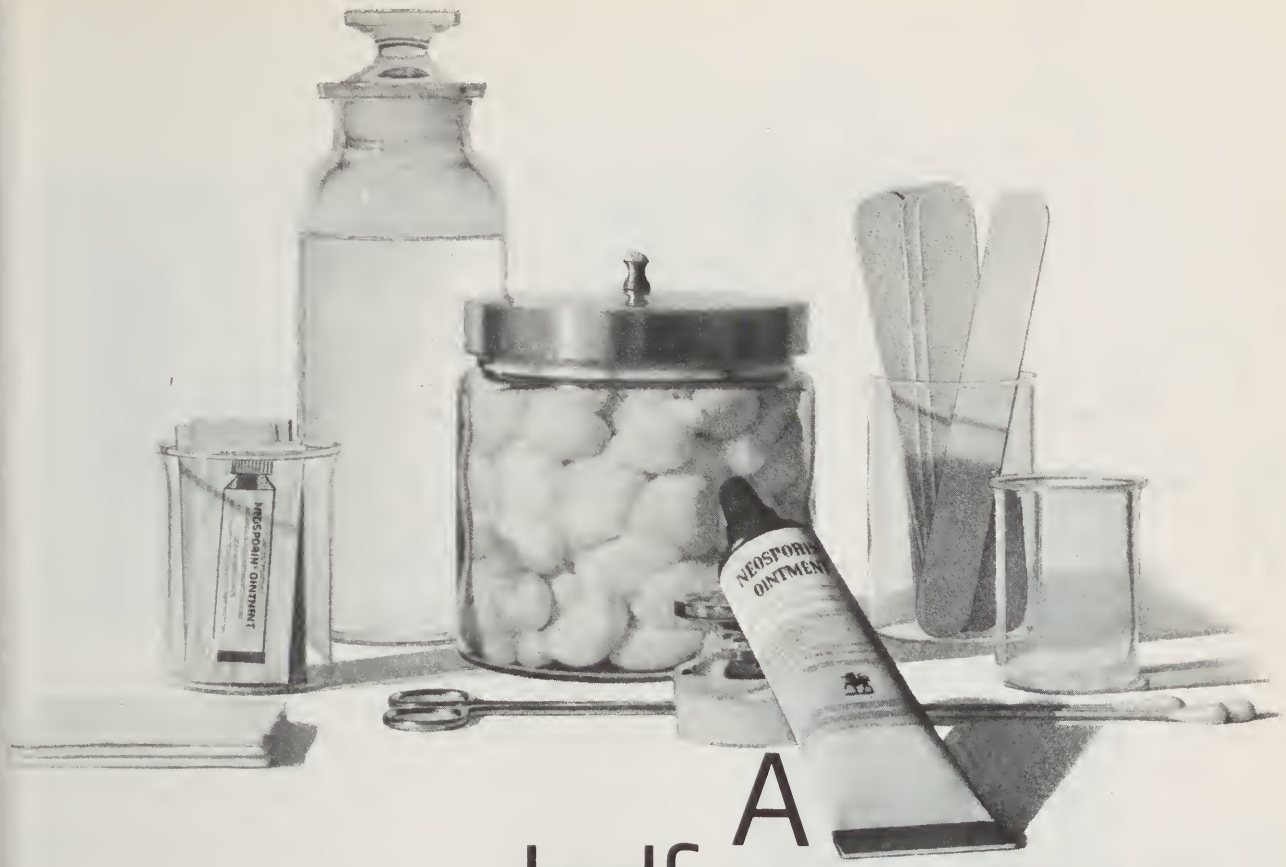
You recognize, I am sure, that "future shock" is the result of the convergence of these streams and that it is no longer "future." It is now upon us all as we, patient and physician alike, are caught in the sticky web of overpopulation, of government, of corporate business and of the computer age with the preservation of the individual and his dignity being the greatest challenge before all society excepting only the preservation of the environment without which there will be no life tomorrow. Escape requires individual effort and recognition that cradle to grave security and freedom do not go hand in hand but are bought only at the price of an individual's responsibility for his own actions and his own life—not alone but joined together with his brothers as each shares his part of the task.

In this predicament—what does the individual seek and what can we as physicians offer or influence to his advantage? We have learned and society is learning that the physician is neither responsible for nor can he cure all the ills of mankind. Automobiles, living styles, food supplies, and political manipulation are all more potent factors in longevity, or the lack thereof, than the knife or digitalis. Yet there are things we can and must do if we are to extricate our patients and ourselves from the web.

First, there is Gargantua—sheer bigness. We cannot stop mergers or the American craze to make big ones out of little ones or the concept that bigger is better, but we can prevent the unresponsiveness of bigness to the needs of an individual from permeating into the practice of medicine more than it already has.

I would urge that in ourselves and in our practices we accelerate renewal of the concept of the patient as a person—not a disease. More than ever does a sick man need the doctor as a teacher who will guide him by

(Continued to page 45)



A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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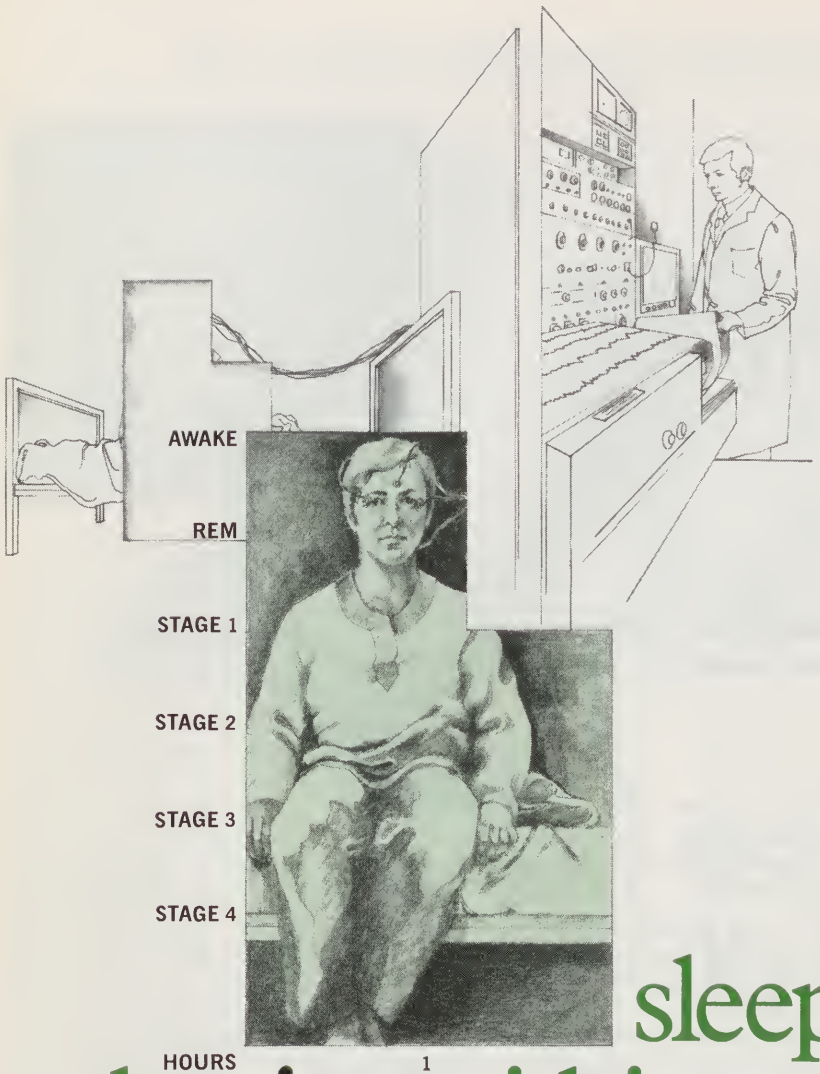


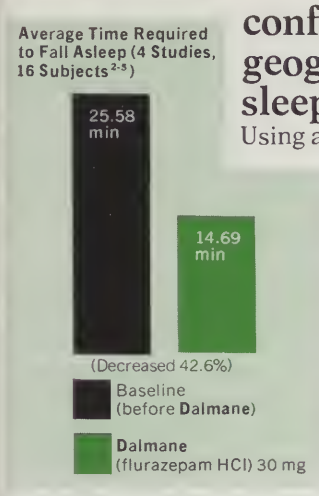
sleep begins within 17 minutes, on average ...

an initial benefit of

Dalmane®
(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

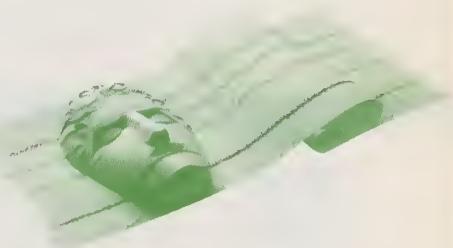
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

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Opinion & Dialogue

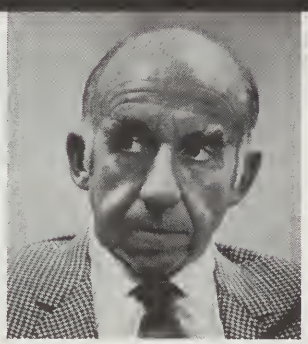
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

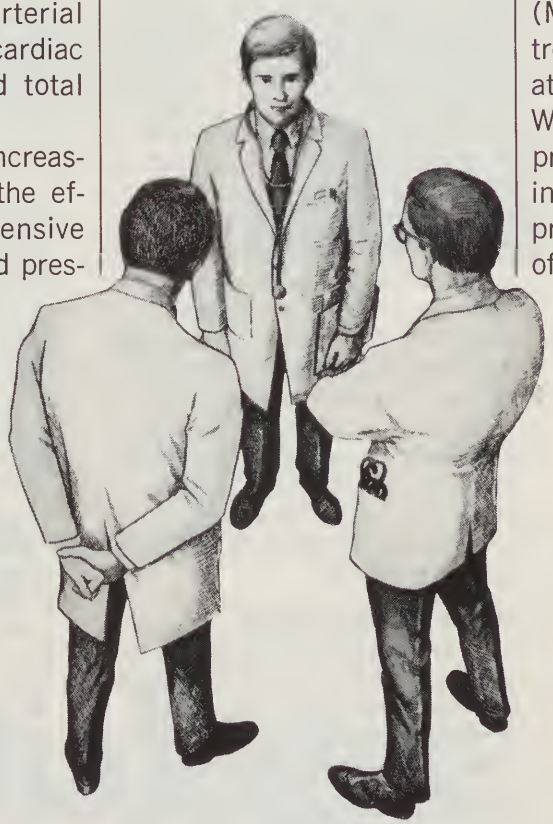
From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

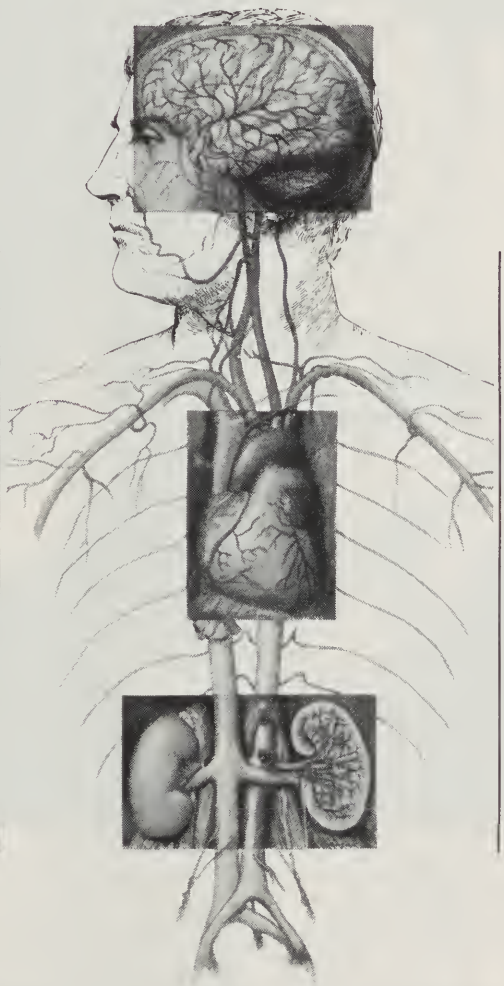
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

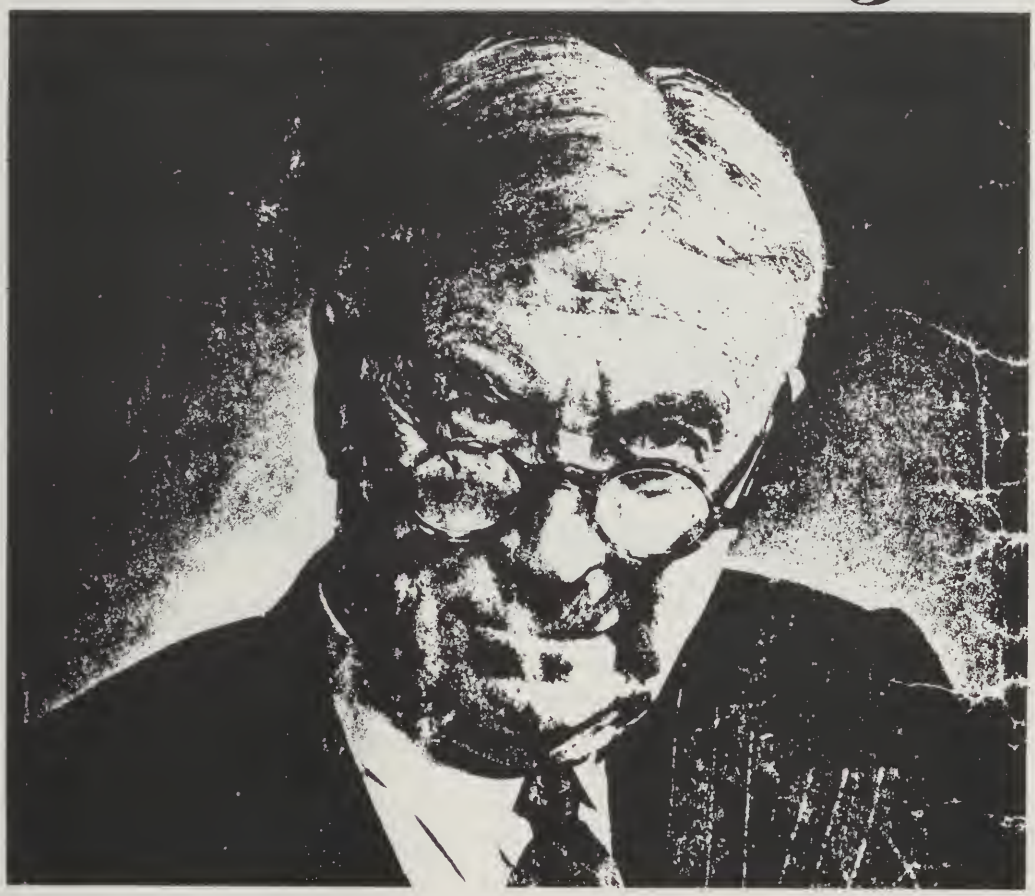
MSD
MERCK SHARP & DOHME

"Required Reading" For Your Hypertensive Patients

Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

"Bernard Baruch saved his fortune by putting his money in silver" ...so can you!



Financial wizard Bernard Baruch saw the problems of the stock market in the late 1920's. A year before the great crash he began converting his investments from stocks and bonds to silver. When the crash came he was completely out of the market.

Silver was his choice to ward off the losses of a declining market. While others lost fortunes, Bernard Baruch emerged a multi-billionaire.

In the past 24 months the stock market has declined 30% while the price of silver has increased 200%. Learn how you can get protection and growth by buying financial silver. .999 fine silver ingots in various sizes are available to suit your particular requirements.

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PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

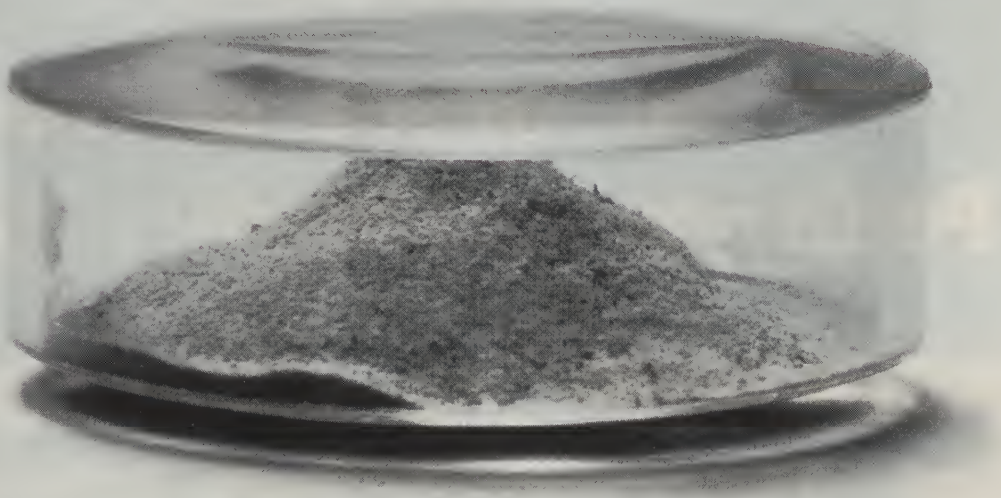
How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

IN NATURAL THYROID THERAPY:

ARE PATIENTS GETTING THE POTENCY YOU PRESCRIBE?



Unlike U.S.P. desiccated thyroid, Proloid®(thyroglobulin) offers the assurance of constant potency.

To begin with, Proloid is uniquely purified. The thyroglobulin extracted from hog thyroid is devoid of any glandular debris.

Then, Proloid is chemically and biologically assayed to assure consistent metabolic activity from batch to batch. The T_4 and T_3 content of every dose is blended for optimal thyroid replacement.

Important, too, is the fact that Proloid is invariably "fresh" when your patients take it. Under proper storage conditions, its potency will not diminish for at least four years.

All of which adds up to this: the potency of Proloid is constant...for more consistent results.

PROLOID®
(thyroglobulin)

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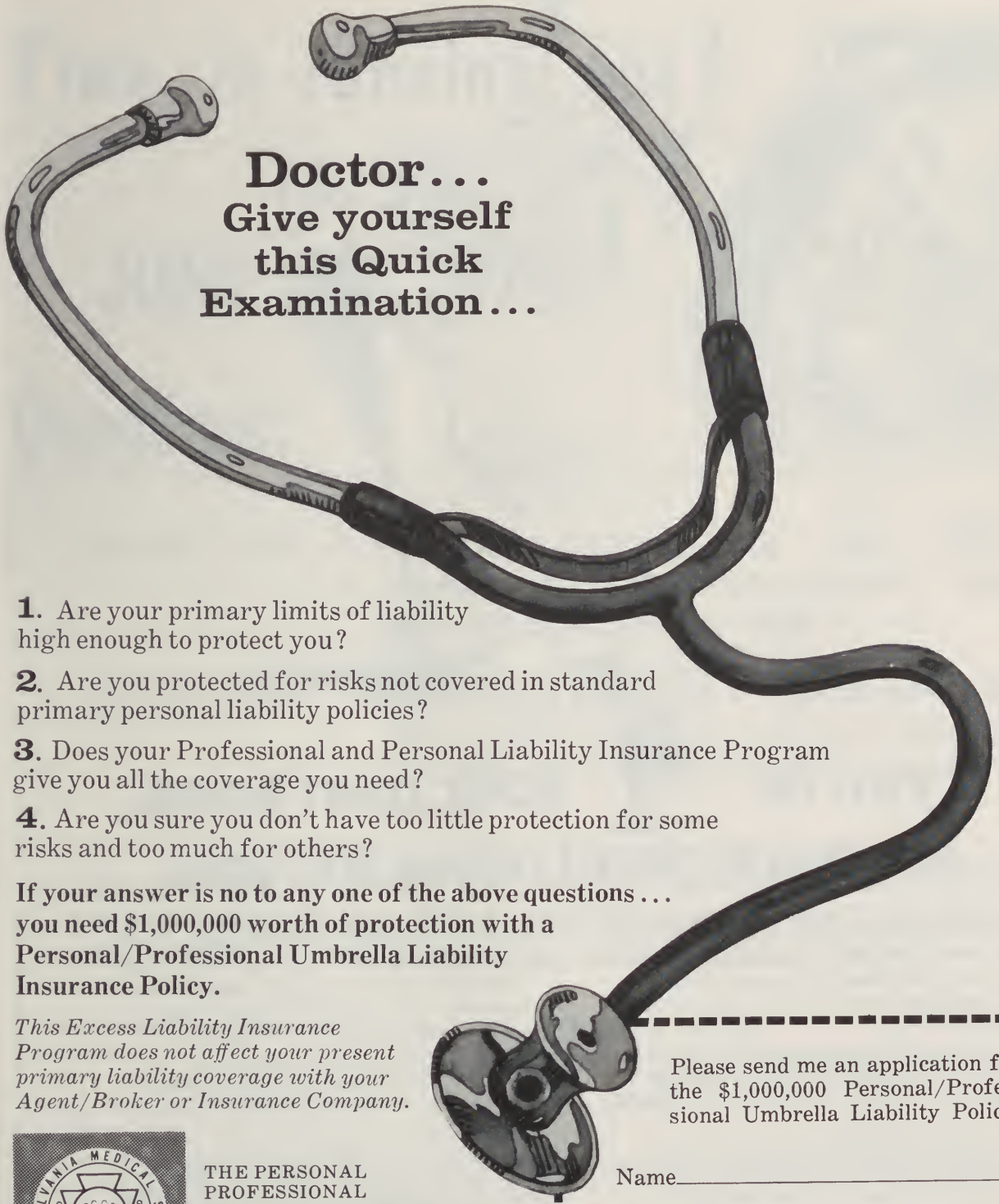

Doctor...
Give yourself this Quick Examination...

1. Are your primary limits of liability high enough to protect you?

2. Are you protected for risks not covered in standard primary personal liability policies?

3. Does your Professional and Personal Liability Insurance Program give you all the coverage you need?

4. Are you sure you don't have too little protection for some risks and too much for others?

If your answer is no to any one of the above questions... you need $1,000,000 worth of protection with a Personal/Professional Umbrella Liability Insurance Policy.

This Excess Liability Insurance Program does not affect your present primary liability coverage with your Agent/Broker or Insurance Company.

THE PERSONAL PROFESSIONAL UMBRELLA LIABILITY INSURANCE PROGRAM HAS BEEN ENDORSED BY THE PENNSYLVANIA MEDICAL SOCIETY

ADMINISTRATOR

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Union Bank Building, Pittsburgh, PA. 15222

Please send me an application for the $1,000,000 Personal/Professional Umbrella Liability Policy.

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If you're your own boss, we have good news for you.

There's a great new tax advantage possible for professionals, business proprietors and other self-employed people, as a result of recent Congressional action on pensions for the self-employed.

Previously, self-employed individuals were allowed a special tax deduction for funds set aside for retirement—10% of earned income with a limit of $2,500.

Now, if you're your own boss, you can salt away perhaps three times as much for retirement, since the annual ceiling on deductible contributions has been raised to 15% with a $7,500 limit.

Pittsburgh National has developed a Master Retirement Plan for people like you—a plan designed to help you get the full benefits under the new law.

All it takes to arrange a meeting is a phone call to our Trust Division at 355-3604. Or send in the coupon for a free copy of our short, easy-to-read folder, "New Tax Breaks in Self-Employed Retirement Planning." We can help your ship come in a little closer to the dock.

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Please send me a copy of your booklet, "New Tax Breaks in Self-Employed Retirement Planning."

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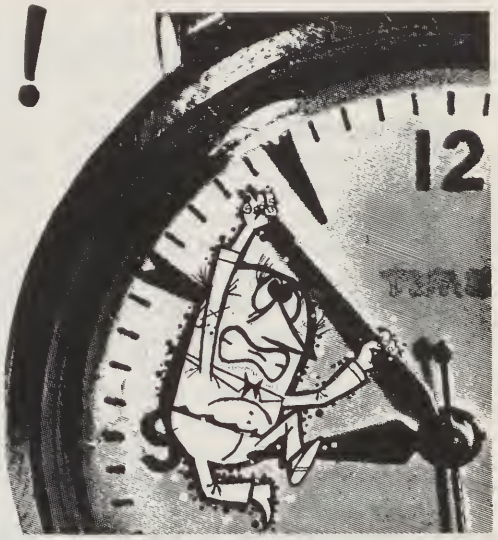

Deadlines:

June 30, 1975 = All applications for the 1974 Physician's Recognition Award must be in the office of the AMA.

June 30, 1975 = This is the last date on which you can take education that can be reported for the current membership requirement.

You will have fulfilled the continuing medical education requirement if you have earned one of the following: 1973, 1974, or 1975 Physician's Recognition Award.

If you need another copy of the application form, contact:

Council on Education and Science • Pennsylvania Medical Society • 20 Erford Road • Lemoyne, Pa. 17043

1974 PRA application forms are available now for reporting education taken between July 1, 1971 and June 30, 1974.

1975 PRA application forms will be available January 1, 1975 for reporting education taken between July 1, 1972 and June 30, 1975.

Continuing Medical Education AWARD

Continuing medical education... now a PMS membership requirement

MDs in the news

Lang-Pao Su, M.D., has been named as associate in anesthesiology at the Guthrie Clinic and Robert Packer Hospital, Sayre, Pa. He is a member of the American Society of Anesthesiology and the Pennsylvania Society of Anesthesiologists.

Ronald S. Berardi, M.D., has been named associate pathologist in the laboratory department of the Henry Clay Frick Community Hospital, Mount Pleasant. He is certified by the American Board of Pathology.

Jesse Weigel, M.D., Pittsburgh, has been named medical director of Emergency Medical Services for the Western Pennsylvania Regional Medical Program. A major focus of the program is the specialized instruction of health professionals, especially courses for ambulance personnel. Dr. Weigel serves as the director of employees and student health services, chairman of the Medical Disaster Committee, and chairman of the cardiopulmonary resuscitation team at North Hills Passavant. He is a certified instructor in cardiopulmonary resuscitation for the Western Pennsylvania Heart Association and chairs the Emergency Medicine and Disaster Committee for the Northwest Allegheny Hospital Corporation and the Training Committee for the Emergency Medical Service Council of the Comprehensive Health Planning Agency of Western Pennsylvania.

MarJeanne Collins, M.D., Philadelphia, has been named acting director of adolescent medicine at Children's Hospital of Philadelphia. She is an associate physician at Children's Hospital and an associate in pediatrics at the University of Pennsylvania School of Medicine.

Tae Hyung Bu, M.D., has opened a practice in obstetrics and gynecology in Erie. He completed a four-year residency at St. Vincent Hospital and Hamot Medical Center. Dr. Bu is attending physician and instructor of residents at the ob/gyn clinic at St. Vincent and is attending physician for the Family Life Center.

A. Richard Kendall, M.D., Philadelphia, has been named professor and chairman of urology at Temple University School of Medicine. Dr. Kendall is a past recipient of the Christian R. and Mary F. Lindback award for outstanding teaching. He is a fellow of the International Society of Urology, the American Urologic Association, the Society for Pediatric Urology, the Academy of Pediatrics, and the American College of Surgeons.

DR. KENDALL

DR. BURNSIDE

The Fifteenth edition of *Adams' Physical Diagnosis* has been completely rewritten and updated by **John W. Burnside, M.D.,** associate professor of medicine and chief of the division of internal medicine at the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. Dr. Burnside was formerly a clinical research fellow in cardiology and medicine at Harvard Medical School.

J. Kenneth Denlinger has been appointed assistant professor of anesthesia at the Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center. He was formerly with the National Institutes of Health as clinical associate in anesthesia. Dr. Denlinger is a diplomate of the American Board of Anesthesiology and a fellow of the American College of Anesthesiologists.

Joseph Weber, M.D., has begun medical practice in his home town of Ashland. A graduate of Lehigh University, he received his M.D. degree from the University of Pittsburgh and completed his residency at St. Francis Hospital, Pittsburgh.

Vincente P. Dinoso, Jr., M.D., has been named associate professor of medicine and associate director of the division of gastroenterology at Hahnemann Medical College and Hospital, Philadelphia. Dr. Dinoso, who will direct the division's research program, is a National Institutes of Health Career Development Award winner.

Two physicians have joined the staff at the Pennsylvania State University College of Medicine at the Milton S. Hershey Medical Center. They are **Harold A. Harvey, M.D.,** assistant professor in the division of oncology, and **Bahu S. Shaikh M.D.,** assistant professor in the division of hematology. Dr. Harvey held a fellowship in medical oncology at Lemuel Shattuck, Pondville, and Tufts-New England Medical Center Hospitals. Dr. Shaikh was formerly chief resident in hematology with the Cardeza Foundation for Hematologic Research at Thomas Jefferson University.

John W. Hirshfeld, Jr., M.D., Swarthmore, has been appointed the second incumbent of the Samuel Bellet Professorship in Cardiology at the University of Pennsylvania School of Medicine, where he is assistant professor. He has been a special research fellow in the cardiology branch of the National Heart and Lung Institute and a fellow in cardiology at Duke University Medical Center.

Laird G. Jackson, M.D., director of the division of medical genetics at Jefferson Medical College, Thomas Jefferson University, presented a scientific exhibit on screening programs for the prevention of Tay-Sachs disease at the recent AMA Chicago convention which was awarded the certificate of merit in the internal medicine section. Three medical students at the college collaborated on the exhibit.

Andrew Lefko, M.D. has been appointed professor of psychiatry at the Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center. He will

direct the psychosomatic consultation service of the department of psychiatry. He was formerly chief of the department of psychiatry and neurology at Walson Army Hospital, Fort Dix, N.J.

Two Hamot Medical Center, Erie, physicians have been elected to offices in the northwestern chapter of the American College of Surgeons. **George J. D'Angelo, M.D.,** chairman of the division of thoracic and cardiovascular surgery, has been elected president. **Robert J. Demuth, M.D.,** chairman of the division of plastic surgery, has been elected secretary-treasurer.

Two Lock Haven physicians, **John W. Crisanti, M.D.,** and **Rizalito Advincula, M.D.,** are opening a medical practice aimed toward eventually developing a twenty-four-hour primary health care program in Renovo. Dr. Crisanti has been director of emergency services at Lock Haven Hospital. Dr. Advincula completed specialty training at Trumbull Memorial Hospital, Warren, Ohio, and is a member of the American Academy of Family Physicians and the American College of Emergency Physicians.

Anna Marie Sesso, M.D., Drexel Hill, has been appointed chairman of the department of pediatrics at Mercy Catholic Medical Center, Darby. She is certified by the American Board of Pediatrics and is a fellow of the American Academy of Pediatrics (AAP) and the International College of Pediatrics. She is AAP consultant for the Head Start program in Pottsville and North Hills and serves on the academy's Accident and Poison Control Committee for the Pennsylvania chapter.

Appointments to the regional advisory group of the Western Pennsylvania Regional Medical Program include two University of Pittsburgh physicians: **Jack D. Myers, M.D.,** professor of medicine, and **Kenneth Rogers, M.D.,** professor and chairman of the department of community medicine. They join **F.S. Cheever, M.D.,** retiring vice chancellor for the health professions and **William M. Cooper, M.D.,** director of the division of continuing education at the school of medicine, who are currently serving.

George R. Hart, M.D., who established a practice in otolaryngology in New Castle recently, received a Meritorious Service Medal at Annapolis, Md., on the occasion of his retirement after twenty-four years of U.S. Navy service.

Three family practice resident physicians will man the new family practice unit in the ambulatory care center adjacent to the Latrobe Area Hospital. They are: **Drs. Melchor M. Carbonell, Bruce A. Hershock,** and **Marvin E. Nielsen, Jr.** Twenty-four hour coverage is available through the program which was made possible by an affiliation between Jefferson Medical College of Thomas Jefferson University and the Latrobe Area Hospital.

J. Arnold Donovan, Jr., M.D., Olean, N.Y., has been appointed orthopedic surgeon at Evangelical Hospital, Lewisburg.

James H. McMaster, M.D., assistant professor of orthopedic surgery at the University of Pittsburgh School of Medicine, and three fellows in the department of orthopedic surgery, **Roger J. Ferguson, M.D., Ph.D., Pierce E. Scranton, Jr., M.D.,** and **Carl R. Weinert, Jr., M.D.,** have received the American Orthopaedic Foot Society Albert E. Klinkicht award for their paper on the dynamic function of the human fibula.

David B. Fishback, M.D., of the Philadelphia Geriatric Center, addressed a meeting of the International Congress of Angiology on the progress of his research on high blood pressure in the aged at Montreal, Quebec, recently.

Gordon K. MacLeod, M.D., has been named professor and chairman of the newly-designated department of health services administration of the University of Pittsburgh's Graduate School of Public Health. He was formerly director of the HMO service of the U.S. Department of Health, Education, and Welfare.

Three Minersville area physicians have been honored for medical service at a testimonial dinner by the Minersville Area Lions Club. They are **Drs. Guy Bashore; A. E. Valibus; and Leroy R. Purcell.**

J. W. Smith, Sr., M.D., has been honored for fifty years of medical service to the Beaver County Medical Society. He is a past president of the society and delegate to the State Society House of Delegates.

Cataldo Corrado, M.D., Uniontown, was honored at a testimonial dinner given recently by the citizens of Uniontown.

Matthew T. Moore, M.D., emeritus professor of neuropathology at the University of Pennsylvania School of Medicine, has been elected to honorary membership in the American Association of Neuropathologists. He presented two papers at the recent Congress of Neuropathology in Budapest, Hungary.

MEDEX Preceptors

Fifteen Pennsylvania physicians are currently training the third class of MEDEX physicians' assistants from the Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center. The students have completed classroom and clinical training programs and have entered the community training preceptor phase of the National Institutes of Health-Funded program. They are:

Earl K. Connors, M.D., Langhorne

Robert B. Edmiston, M.D., Harrisburg
Robert L. Barton, M.D., Hershey
Bertram L. Johnson, M.D., Columbia
William B. Landis, M.D., Columbia
Ira G. Wagner, M.D., Ephrata
Suzanne H. Worrilow, M.D., Lebanon
Fernando F. Araya, M.D., Forty Fort
Edward A. Lottick M.D., Kingston
John L. Cionci, D.O., Philadelphia
Edgar Escobar, M.D., Philadelphia
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practice management

Doctors benefit from Pension Reform Act—Part I

LEIF C. BECK, LL.B.
Bala Cynwyd

The Pension Reform Act of 1974 finally became law on Labor Day, September 2, 1974, after years of proposal and debate. At various times in the past few years there had been possibilities that this Act would be quite harsh to most medical practices, whether incorporated or not, but in my view the final legislation is reasonable. In fact, the legislation will be working to many more doctors' benefit than detriment.

It is, however, important that doctors be acquainted with the basic effects of the Pension Reform Act for their own protection and planning. This series of articles is intended to serve that limited purpose, while readers must recognize that the Act's complexity requires each practice to receive extensive leadership from its attorney, accountant, or other advisors.

Most of the Act's changes regarding Keogh plans and other noncorporate opportunities apply to this present calendar year 1974. To provide my readers with background to consider what they might do promptly before this year runs out, I will first discuss those provisions. Most of the changes affecting existing professional corporation retirement plans will not apply until taxable years *beginning* in 1976—a rather long interim period. New corporations and newly adopted retirement plans (those adopted after the Act became law on Labor Day) are, of course, subject to the new rules right away. The corporate changes will be discussed next month.

Keogh Plans

1. Contribution Increase—The most dramatic favorable change, of course, was the Act's increasing allowable contributions to Keogh plans. While the old maximum contribution was 10 percent of net income from practice or $2,500, whichever was less, the new limitation is the lesser of 15 percent of net income or $7,500. Thus, under the new rules, a physician whose net income is at least $50,000 could adopt or revise a Keogh plan to provide for $7,500 annual contribution for himself.

This change is effective for the present calendar year 1974, so that the increased contribution could be made this year. Although many unincorporated doctors will want to take advantage of the change right away, I urge some caution. Keogh plans are typically handled through "master" or "prototype" agreements with banks, life insurance companies, and mutual funds; and those documents will first have to be formally amended to permit contributions above the presently worded $2,500 limits. Therefore, a doctor should not simply send additional moneys to his present Keogh plan until receiving assurance that it has been properly amended.

A Keogh plan must still, of course, benefit the owner's employees as well as himself. Hence, increasing the contribution for the physician-owner will also cause an increase in the cost of covering his aides. This should not be objectionable since if the cost was acceptable at $2,500 it should be equally desirable as a financial matter at $7,500.

The new Act will permit some self-employed persons to contribute more than $7,500 for their own account. It provides certain fairly complex special limitations for actuarily calculated "defined benefit" or "fixed benefit" plans which would, for instance, permit a doctor age 45 earning $60,000 per year to contribute and deduct $9,800 per year. This defined benefit plan might also permit him to contribute proportionately less for his aides if they are younger than him, an additional advantage of this approach.

Defined benefit plans have a variety of disadvantages, as I have periodically described in prior articles dealing with professional corporations. Most of the disadvantages would apply equally to Keogh plans using the defined benefit approach. Hence extreme restraint should be exercised before any doctor decides that the opportunity to contribute more than $7,500 justifies that approach. The defined benefit plan is especially popular among life insurance-oriented pension advisors, and I would urge that any such proposal be reviewed with other advisors not having the same commission interest in the insurance sale.

2. High Income Restriction—While permitting the increased Keogh contribution rate, however, the Act established one new restriction that will particularly affect very high-income physicians. It requires that no more than $100,000 of a person's net income may be taken into account in determining the contribution rate for himself and his employees. This has the effect of assuring a reasonable contribution for the participating employees. For example, were it not for this special rule, a person earning $150,000 could set a contribution rate of 5 percent for himself and his employees and still set $7,500 aside for himself. Because of the limitation, however, he would have to set the rate at 7.5 percent, thus increasing the actual amounts contributed for his employees.

This $100,000 restriction applies only to owners under Keogh plans (and shareholders holding 5 percent or more stock in "subchapter S corporations"). It does not apply to normal professional corporations, and hence it would seem that physicians with such high incomes would continue to prefer incorporation to the Keogh alternative. In fact, I estimate that the basic

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Keogh improvements will still make professional incorporation preferable to most (but by no means all) doctors whose net incomes exceed $60,000. The comparison between the two alternatives becomes much more significant because of the Act, but incorporation continues to hold many advantages.

3. Voluntary Contributions—Even though deductible contributions have been increased to $7,500 (or 15 percent of net income), the Act did *not* increase the maximum extra amount which a doctor can contribute as a "voluntary contribution." So long as the Keogh plan covers at least one common-law employee in addition to the doctor or doctors, then each person in the plan may voluntarily contribute up to 10 percent of his net income or salary, as the case may be, but not more than $2,500 per year for any owner. This 10 percent/$2,500 limit remains unchanged.

Doctors unfortunately tend to ignore or forget the opportunity to make voluntary contributions. A person need not make such payments each year, nor need all persons in the plan make them in any particular relationship. Voluntary contributions are completely discretionary with each individual on an annual basis. Such extra contributions are not deductible by the person on his tax return, but once contributed they earn income and compound annually *tax-free* until that income is paid over to the person. This opportunity to put additional moneys into a tax-free fund can be extremely valuable, and it is unfortunate that the limit did not increase to the 15 percent/$7,500 level.

The Pension Reform Act did, however, make one change which should make voluntary contributions much more appealing to doctors in Keogh plans. Plans may hereafter permit a person who made a voluntary contributon to withdraw it (but not the earnings thereon) at any time without penalty. Previously, Keogh plans had to require that any amounts held for an owner-participant must be retained at least until that person reached age 59½. The significance should be obvious; a doctor might contribute an extra $2,500 to his Keogh plan each year for four years and then withdraw up to $10,000 to pay his children's college tuitions, the moneys in the meantime having generated income on a tax-free compounded basis for retirement.

While improved, the Keogh restrictions on voluntary contributions continue to be a factor in favor of creating a professional corporation. Corporate retirement plans may permit a person to voluntarily contribute up to 10 percent of his salary per year on an *aggregate* basis. Thus, a doctor on a salary of $50,000 per year could, for example, skip making voluntary contributions for three years and then contribute $20,000 (10 percent of $50,000 times four years) in the fourth year. That amount might have come to him as an inheritance, from the sale of a piece of real estate, or the like. Under Keogh, he could only contribute $2,500 in that fourth year.

4. Contribution "Grace Period"—There is another change which will be heartily welcomed, at least by physicians' accountants and advisors. It will permit contributions to a Keogh (or corporate) plan to be made *after* the taxable year ends and yet be deductible for that year.

It is extremely difficult to calculate the exact amount of a deductible contribution to be made by a "cash basis" practice since the amount is a function of both the practice's net income and the exact salaries paid during the year. Most accountants must calculate it with an element of guesswork, risking tax penalties for overcontributing to Keogh plans.

The new rule, effective for existing plans only after 1975, will allow the contribution to be made within the time the practice's tax return is due (March 15 for a partnership and April 15 for an individual), plus any extensions of time granted for the filing. This will allow the accountant normal time to prepare the proper financial statements and calculate the contribution.

5. Tax on Lump Sum Distributions—Additionally, the Pension Reform Act has changed the income tax treatment of distributions from any retirement plan (upon a person's retirement, death, or otherwise) in a manner which is extremely favorable to Keogh plans. Under old law, the taxes imposed on Keogh moneys paid over because of a doctor's death or retirement were so onerous that some people chose incorporation because of that future difference. There was, for example, no capital gains tax possibility at all upon such a payout.

The Act has now provided for uniform income tax treatment of lump sum distributions from Keogh plans and from corporate plans. That treatment would permit a *portion* of anyone's interest in a plan funded before 1974 to be taxed as a capital gain. The portion would simply be the ratio of years prior to 1974 to total years of plan participation, multiplied by the total lump sum received from the plan. Thus, if a doctor had adopted a Keogh plan in 1969 and should retire in 1984, one-third (five years prior to 1974 divided is 15 years total) of the amount then in the fund and paid over to him would be taxable as a capital gain. This is apparently true *even if* the doctor's contributions hereafter are $7,500 per year and yet were only $2,500 per year in the past!

While this Act provision was intended to provide a phase-out of the capital gains provision, which will occur over the years, it actually provides existing Keogh plan participants with a tax benefit never available in the past. What is more, even as to new Keogh plan participants and contributions to existing plans hereafter, a new special tax averaging rule applying to future distributions will be quite helpful. That rule would essentially take one-tenth of the lump sum distribution (less a certain allowance and any capital gains portion) and multiply the tax thereon by ten thus keeping the progressive tax rate down somewhat. The calculation is extremely complex, but the net effect would remove the ultimate income tax as a difference between incorporation and Keogh.

There are restrictions on the new averaging rule. It may not apply unless one has been a participant in his plan for at least five years; and as to Keogh plans, it will not apply unless the owner-doctor is at least age 59½ when the distribution is made (unless on account of his death or disability). There is also a very difficult "six year

lookback rule" to prevent taking tax advantage of these special arrangements several times within a limited number of years. These complicating factors should not affect one's basic considerations in adopting a plan.

6. Estate Tax Situation Unchanged—While the new Act made income tax treatment of a Keogh plan pay-out more desirable, it unfortunately left untouched one item of decided advantage for corporate retirement plans. This is the Federal estate tax exemption, which does not extend to Keogh plan distributions. If one compares a number of years' participation in both a Keogh and a corporate plan and assumes the doctor's death before retirement, the after-tax difference between the two plans may be dramatic—often a reason to prefer incorporation. I am disappointed that the disparity was not resolved by the Pension Reform Act.

Subchapter S Corporations

Ever since the 1969 Tax Act, the opportunity to take advantage of incorporation, while avoiding most of the tax problems by use of a "Subchapter S election," has essentially been unavailable. Under subchapter S, a person could incorporate and adopt the usual employee benefit plans but nevertheless have that corporation ignored for purposes of Federal income taxation. Any corporate income would be passed through and taxed to the shareholder(s) as though the corporation did not exist, thus removing the commonly discussed problems of "unreasonable compensation," "personal holding company" treatment, double tax corporate profits and dividends, and the like.

In 1969, retirement plans of these so-called "tax option corporations" became limited to the same $2,500 contribution for shareholder-employees as under Keogh plans. Doctors have rarely used subchapter S since then. The new Act, however, has increased the deductible limit for such corporations to Keogh's $7,500 level. In fact, most of what has been described heretofore with respect to Keogh plans also applies to corporations electing subchapter S treatment.

I believe the increased contribution limit and other changes will make subchapter S a very good choice for a wide variety of both existing and new professional corporations. Such a corporation will avoid the named corporate tax problems, while it can adopt all the other fringe benefit plans not available tax-wise to an unincorporated practice. These other plans include tax deductible health, disability and group term life insurance premiums, and medical expense payments for employees. What is more, the death tax exclusion applies to a payout from a sub-chapter S corporation's plan although, as described, not from a Keogh plan. And the higher corporate limits apply to voluntary contributions as well.

An existing professional corporation can elect to be taxed under subchapter S within the first thirty days before or after any fiscal year begins. A new corporation can likewise make the election at its inception. The election can be revoked at the beginning of any succeeding year, and thus choosing this form is not an irrevocable step. For the many practices in which the anticipated contribution level for its doctor(s) is perhaps $5,000 to $7,500, I believe the tax option election deserves extremely serious consideration.

While its concept is simple, subchapter S is a very complicated portion of the tax code. There are a variety of tax "traps" a subchapter S corporation can fall into unless it has expert leadership and advice. Hence, I urge that any doctor considering taking advantage of this new opportunity be sure his attorney and/or accountant are sophisticated in tax matters and experienced with subchapter S.

Individual Retirement Accounts

The Pension Reform Act also created a brand new retirement funding arrangement, known as the "individual retirement account" or IRA. It will allow any individual not participating in a qualified retirement plan (whether corporate, Keogh, tax sheltered annuity, or otherwise) to create a small plan solely for himself. He may contribute and deduct up to $1,500 (or 15 percent of his net income or salary if less, which would be rare) per year, and if his spouse is similarly in business or salaried they each could do so for total deduction of $3,000 per year.

An IRA is treated very much like a Keogh plan. A bank or other person satisfying new IRS rules must be the trustee, or else the IRA can be invested in annuity contracts. It cannot, however, be invested in life insurance. As with Keogh funds, it cannot be paid over to the individual before he reaches age 59½ without a penalty tax, and it must begin to be paid out by age 70½.

A number of doctors have neither incorporated nor adopted Keogh plans for valid reasons. This is particularly true of larger group practices where the variations in personal interests and desires have resulted in no action at all. Similarly, where the ratio of common-law nonprofessional help to doctors has been high, the cost of contributing for those other persons has discouraged adoption of any plan at all. In these and other special situations, a doctor may now *individually* make some provision for his future by adopting his own IRA. He need not coordinate it with his partners, his aides, or anyone else; for the IRA covers only himself. While the annual amount is small, it is some opportunity for tax deductible self-help and should not be ignored.

Banks, savings funds, and the like will undoubtedly be offering IRA opportunities before the year ends. Some will hopefully offer options to have the individual amounts invested in interest-bearing accounts, whether certificates of deposit or simply savings accounts. Insurance companies will presumably offer IRA annuity contracts at guaranteed interest rates. A doctor in his mid-forties investing $1,500 each year into an IRA paying 7 percent interest would accumulate a fund of roughly $65,000 at the end of twenty years. Although the fund would be taxable as he withdraws it, this opportunity through a steady income-producing investment would seem preferable to one geared to stock market fluctuations when so little is involved annually. The dollar potential at even the IRA level is certainly worthwhile.

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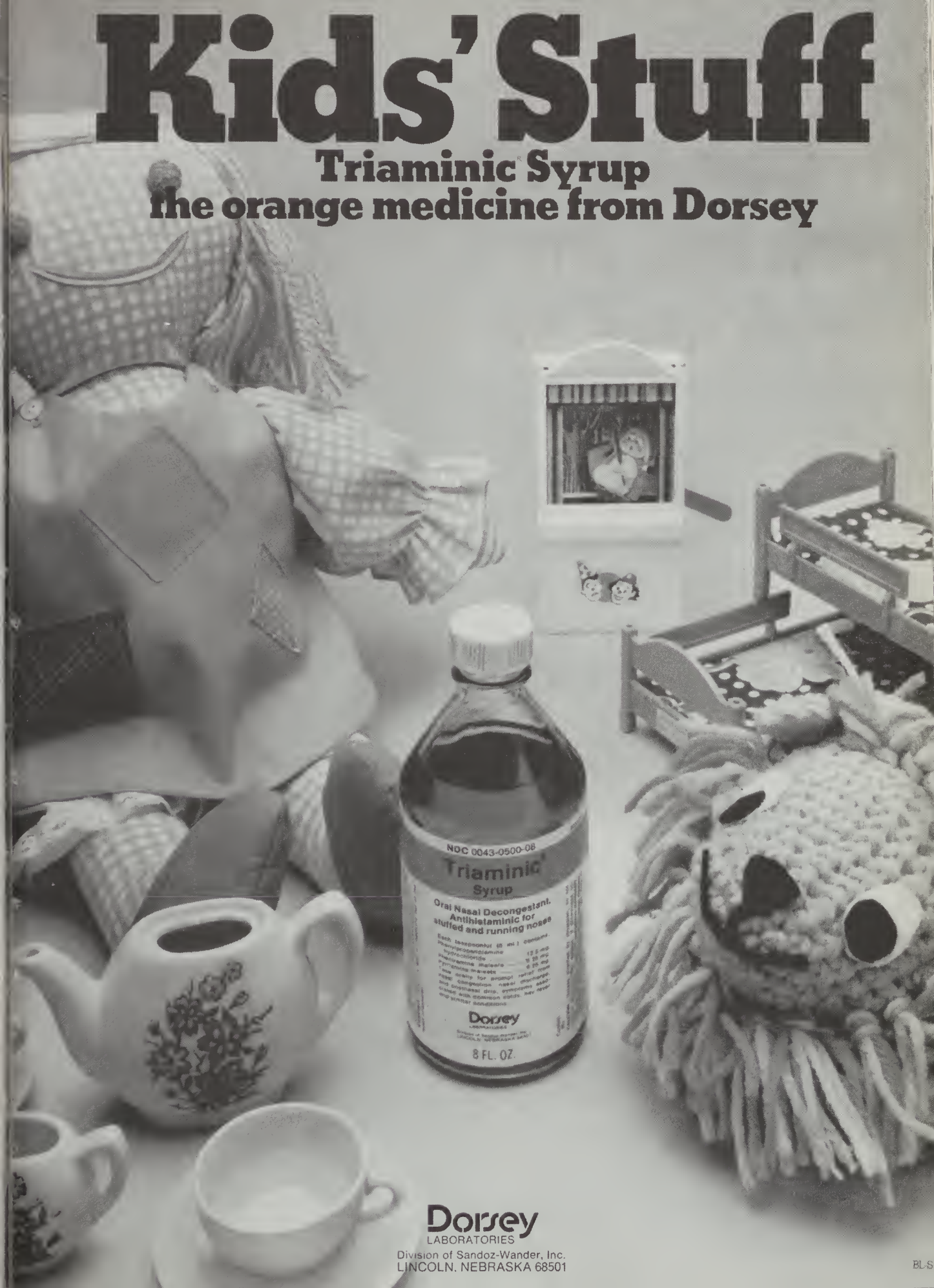

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1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

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Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

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Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

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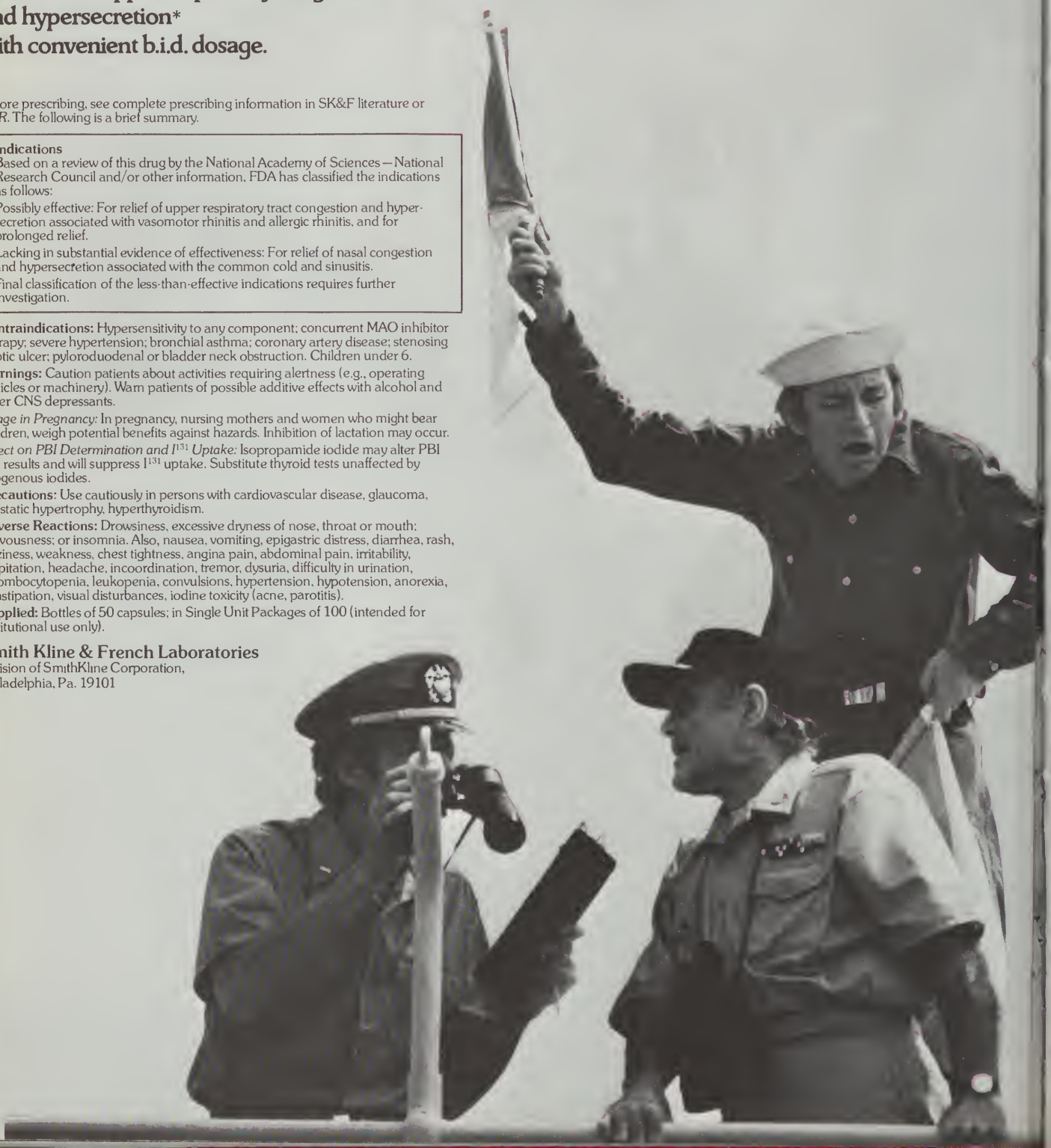

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Dr. Crane speaks to delegates

(Continued from page 18)

a sense of concern and of warm understanding. Unfortunately, the successful business of medicine with multiple office units, nurses, secretaries and technicians, and well-timed schedules becomes but another strand in the entangling web, along with government, corporate business, and the computer, further stripping man of his individuality and his dignity. We should take a critical look at the various assistants we use to be sure that their roles are for the benefit of the patients and not for our own. The Russians have found their feldsher system a poor substitute for a doctor and are abandoning it at a time when the innovation fad in this country is pushing for physicians' assistants. As a pathologist I need and use the help of many hands with special skills, an experience which makes me quite aware of the uses and abuses inherent in the expanders of health care. We should use them wisely but be sure that innovation, despite the demand for it, does not become the goal rather than the means to achieve our real purpose: **Personal health care rendered by well-trained physicians.** The most difficult part of medical care is the initial patient-physician contact. It requires great skill, broad knowledge, confident understanding, and precise decision. These are skills that do not reside with the specialist for whom the problem is already circumscribed, nor are they the skills of the expander. They are the skills of a doctor, the teacher, needed at the close of the Twentieth Century by man above all else in his search for total health.

The role of the assistant in medicine leads directly to the concern of the preservation of standards of education and training in the healing arts. Licensing of persons to practice "pieces" of medicine independent of physicians; payment of cultists with government funds; and the wide use of poorly qualified foreign medical graduates, for which we are in no small part responsible, are rapidly moving the practice of the healing arts backward to pre-Flexner days. We all have seen good, well-qualified, American students rejected from the mainstream of medicine while poorly trained persons of uncertain and uncorroborated educational backgrounds are allowed to take care of patients—all too often without direct supervision.

The answer lies in a more responsive and responsible enrollment policy in our medical schools and an end to free entry into practice of medicine by persons whose professional training does not meet American standards. We should also hold the moratorium on "licensing" of paramedical personnel. But this will be difficult, for, to an increasing extent, the programs in paramedical fields are being filled with men educated in this country and of an intellect and educational background qualifying them for training in medicine or any part thereof. They are no longer rejects for lack of qualification but rejects "because there is no room in the inn."

There then comes the matter of helping the patient to carry the cost of illness, and here we have a great responsibility to see that he is not short-changed by third parties who promise all, but welch on delivery, shifting the blame where they can, usually to the medical practitioner. The concept of protection for a limited number of days or for limited conditions under insurance programs blocks the goal. We must seek the removal of time restrictions from all health insurance plans including those promulgated by government. The man who really needs coverage is the one who, because of recurrent illness, will require 90 or 120 or more days of hospitalization or of convalescent care. Unfortunately the writers of health insurance seek to sell their wares to people who are least likely to need them. In this regard government is no less an offender than any other. Perhaps one of the most deceptive concepts in health insurance is that of merit rating, the result of which is that the lion's share of the cost is borne by those who can least afford it—those who are subject to illness. It makes a farce out of programs for the employment of the handicapped, for employers are loath to hire persons who will increase their health care costs—a great plan for selling and making money, but a horror for medical care.

The adverse effects of the intrusion into patient care by third parties are now becoming clearly evident. Two months ago I took on chairing a utilization review program and almost immediately was shocked by the refusal of Blue Cross and the Department of Public Welfare to cover the needs of really sick patients under the guise of utilization. Demands that the final days of hospitalization be reduced are demands for the practice of bad medicine and must be exposed for the ruse they are. A demand that a woman with postoperative ileus, acute pancreatitis, and pulmonary embolism be discharged the day her temperature returns to normal after three weeks of spiking fever, abdominal distention, nausea, and vomiting threatens life by bureacratic budgeting and bungling. When demanded of patients on medical assistance it further penalizes an already underprivileged minority. May the responsible bureaucrat know the thrill of trying to get to a hospital with an acutely distended bladder when the Department of Public Welfare refuses 24 hours of observation after three episodes of postoperative bleeding and acute urinary retention following prostatic surgery. Review of hospital cases both concurrent and retrospective *must* be through the PSRO mechanism, and in-house. It must not reside, ever, in the hands of insurers, government or otherwise if we are to champion the needs of the individual as we must. Savings will come, not from picayune manipulation of individual claims but as we gain the ability to eliminate or contain diseases. The days before surgery and after illness are good days for medical care and should not be sacrificed on the altar of politics. We should demand them and use them for their importance to total medical care, for the recognition of the worth of the individual to society. Review mechanisms leaving the final say in the hands of the money changers cannot stand, for it is all too clear that saving of money and not of health or even lives becomes a yard stick. We must give our full support

and our efforts to building our own review mechanism through PSRO using the help and guidance of the Pennsylvania Medical Care Foundation which has prepared the way so well.

Fraudulent advertising which takes the form of promised programs which are not properly funded for delivery by the government or the form of liberal use of fineprint exclusions by both nonprofit and for-profit carriers misguide the patient and discredit the health care system. We should see that coverages are clearly stated and exclusions eliminated from all health care policies and plans. Bureaucratic pretentions must be exposed for what they are. When a person in public office says that no additional funds will be spent on existing programs that have already saved millions of dollars but will be spent on *new* programs, and when those new programs exist only as ephemeral plans and are not functioning nor have even been tried, then there can be no confidence in health planning or funding by the government.

The cost of illness is now proportionately less than it ever has been and we must see that this fact is given the priority it deserves. The early diagnosis, precise treatment, and early return to productive life have made impotent such killers as pneumonia, appendicitis and meningitis, and have tremendously altered the costs of the more chronic conditions of heart disease, cancer, and stroke. Just compare the morbidity of resection of the colon for carcinoma in 1974, in 1944, and in 1924—the American citizen can buy no better product of any kind at any price in the whole of the American marketplace. It is our duty to see that the patient receives from government and from third parties all he has paid for and to see that his life is not jeopardized by the counting of days in Washington or Harrisburg by those, be they laymen or physicians, who have never stood by his bedside.

The financing of medical care pleases no one, for none of us likes to pay for our misfortunes. Whether the financing is direct and clearly evident or hidden in general taxes does not alter the palatability. A uniform type of national health insurance has to come, for the confusion of multiple types of coverage has become increasingly unacceptable to both patient and physician. Direct financing is preferable for it prevents the type of subterfuge that has made Title XIX such a farce in this state. The Medicredit program of the American Medical Association is the most reasonable of all proposals that have been presented as clearly shown by the multitude of its sponsors. It distributes the cost on the basis of the ability to pay which is as it should be and is direct and honest—probably its only drawback. We should be more vocal and active in enlisting our support for it especially among our patients.

Alteration in the financing of medical care will not and should not eliminate the existing carrier systems. There is an active effort to remove Pennsylvania Blue Shield from any association with the Pennsylvania Medical Society which would be a very unfortunate occurrence for Blue Shield and for our role in influencing the financing of medical care. Blue Shield was started by the Pennsylvania Medical Society to help the patient and the doctor, and the personal interests of both are most effectively served by close integration. Forced addition of other practitioners makes it even more important that the position of the Pennsylvania Medical Society be strengthened if we are to prevent exploitation of our patients by further legislative action taken for reasons of political gain rather than concern for the quality of health care. Payments for physicians' services are badly in need of development of a true scale of relativity. So-called relative value scales are relative to procedures only within limited specialty areas and make no pretense of relating the value of procedures between specialty fields. It is all too clear that those physicians in the non-surgical areas are getting and have gotten the short end of the stick.

I recommend that our Council on Medical Service and Blue Shield evolve a system, difficult as it may be, which will make the services of all physicians truly relative to each other.

An increasingly binding restriction to our efforts and an intrusion into the patient-physician relationship is the law. We should not be lulled into a false sense of security by the present program of malpractice coverage with Argonaut—effective and responsive as it is. The basic problems remain and are not altered by coverage. Intrinsic malpractice problems are largely those of interpersonal relationships between a doctor and patient. We must continue our good efforts to educate our members in their personal public relations. Extrinsic problems are such things as patient expectation of perfection engendered by unrealistic press, radio, and TV presentations and our own overemphasis of the possible rather than the probable, the concept that inherent risks are not risks but the result of poor medicine, and, finally, the contingency fee system with its concept of pain and suffering which generates profit for the lawyer in proportion to his effectiveness in promoting that abstraction. We must seek the elimination or restriction of the contingency fee system, difficult as that may be. In New Jersey, a rule of the court restricting the contingency fee to 50 percent of the judgments up to $10,000 and scaling down to 10 percent for judgments of $100,000 or more is a step in the right direction and has been upheld by the Supreme Court of that state. Support from the legal profession or its organizations cannot be expected in this effort for the present adversary system, useless and obsolete as it is in matters of medical science, is the bread and butter of the law, lawyers, and judges. We must also seek to develop and have accepted by the courts a suitable and workable definition of informed consent—not a legal definition forced upon medicine, but a medical definition accepted by the courts in the interest of patient care and the preservation of all the rights and dignity of the individual.

I recommend that our Commission on Professional Liability and the Argonaut Company vigorously pursue the development of a no fault risk type of insurance that can be purchased by the patient to protect him from the risks inherent in every medical procedure and thereby

remove the risks and side effects of all medical treatment and compensation therefore from the courts, making it a specific, covered liability.

The law is also beginning to dictate medical practice, especially ominous being a report from the State of Washington of a decision by the Supreme Court of that state which, on its own, without supporting medical testimony, decided that tonometry should have been done on a thirty-two year old woman who later developed glaucoma. In Washington, D.C., the District Court ruled that a throat culture should have been taken in a twelve-year old girl seen for urinary tract infection, anemia, and grippe, and who later developed rheumatic fever—again without any medical advice or consultation on the matter. Regardless of the merits in either case, the ominous thing is dictation by the courts without supporting advice as to the details of medical practice. We must seek the means to convince the court that laws, judicial decisions, and the adversary system do not constitute an informed approach to the management of disease states.

It is essential that we all recognize that those who are now managing the payments for medical care, and note I say the payments—not paying the costs, for the costs in the final analysis always come out of the pocket of the patient—are increasingly placing dangerous restrictions upon the practice of medicine, ably abetted by the legal system, and to the detriment of the public health. A strong, dedicated, and unified action by all physicians is necessary to cope with this infringement. We of the Pennsylvania Medical Society can be most effective in breaking the tangle of the web by joining with our colleagues over the country to support the base and trunk of medicine—the American Medical Association. A unified medical profession will be a more effective profession for, while there are many diverse talents and goals among the various branches of medicine, they find a common bond in the fact that each physician is a doctor, a teacher. The United States of America is a great country, but I do not approve of everything she has done; religion is a great force for good, but I do not approve of everything it has done; and the American Medical Association has given outstanding leadership in developing the standards of good medical care, but I do not approve of everything it has done. Yet, of each I am proud; proud to be a part and proud to support. In each there are shirkers, there are deserters, there are malcontents. And if they go elsewhere I am sorry—sorry for them, but shall not miss them.

I recommend that we require membership in the American Medical Association of every member in the Pennsylvania Medical Society, for one cannot be a citizen of the Commonwealth of Pennsylvania and refuse to be a citizen of the United States of America and it is the United States of America and the welfare of its citizens we are gathered this week to promote.

REFERRALS

Recommendations concerning the development of a system making services of all physicians relative to each other and the recommendation concerning the development of no fault insurance were referred to the Reference Committee on Medical Service A. The recommendation requiring membership in the AMA was referred to the Reference Committee on Constitution and Bylaws. All other recommendations made by Dr. Crane were referred to the Reference Committee on Reports of Officers.

Recall of events while under general anesthesia

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Hershey

IT IS a common misconception of lay and professional people alike that general anesthesia is an "all-or-nothing" phenomenon. Most patients believe that the anesthetic agent turns consciousness off the way a light switch turns off an electric bulb. The apprehensive person says, "Don't tell me anything; just put me out" (meaning unconscious, completely oblivious). In the public mind there are but two states as far as anesthesia is concerned: Out and not out. General anesthesia, however, is not an out or not out state. It is the purpose of this article to alert readers, be they physicians or not, that even in deep general anesthesia, sensory reception takes place in many patients. It is my further purpose to discuss the significance of this fact as it bears on patient care in the practice of anesthesia and intensive care medicine.

It should come as no surprise that anesthetic depression of the nervous system is a dose response relationship, a continuum of effects extending from the full awareness of the normal to death in the event of drug overdosage. There are no discontinuous functions in biological systems. It should, therefore, not be surprising that in this continuum there may be levels or states of anesthetic depression in which some functions remain intact, while others are inoperative. For example, there is ample evidence that audition retains its function long after consciousness is lost.[1]

Similarly, if memory is a function of the central nervous system (CNS), one would anticipate the theoretical possibility that it, too, might be separable from consciousness. Hyman reported, for example, complete amnesia in forty-five women who received ketamine (0.25 mg/lb) for obstetrical delivery even though they all communicated with him and responded to commands at all times during the procedure. They were conscious but amnesic.[2] There is evidence that unconscious perception and recording of events in unconscious memory bank occurs not uncommonly during general anesthesia.[3,4]

Since general anesthesia involves a continuum of dose response, there is also the theoretical possibility that once agent

levels become low enough, bits or pieces of sensory experience recorded in the memory during the unconsciousness of anesthesia might become available to conscious recall after recovery. Once again evidence clearly indicates that this occurs in clinical practice.[5-9]

Several developments have probably increased the incidence of such conscious recall in the postoperative period in recent years. The employment of very light planes of anesthesia has increased, in conjunction with drugs which can totally paralyze the striated muscular system without depression of the CNS, particularly in patients of poor physical status. If insufficient CNS depressants are used, the result is a more or less awake but paralyzed patient who can feel, hear, and sense but cannot communicate even though he can think and will. The increased use of this so called "balanced" anesthesia stems from reluctance to use flammable anesthetic agents such as ether and cyclopropane on the one hand, and the attack on volatile halogenated compounds such as halothane (Fluothane,® Ayerst) and methoxyflurane (Penthrane® Abbott Laboratories) because of their organ toxicity on the other. The public may learn to accept increased use of regional anesthesia, but general anesthesia will doubtless be called upon to handle the bulk of cases. Balanced anesthesia is the most acceptable alternative to the use of explosive or volatile agents. For this reason, recall of events under general anesthesia is a matter of increasing clinical and research interest.

In our department for three months during the summer of 1972, we interviewed every patient who received general anesthesia employing nonflammable and nonvolatile agents. One hundred five patients were interviewed postoperatively daily for three days, or longer in those cases in which some recall was elicited. Of these 105 cases, there were seven patients who on questioning could recall specific events which we could definitely relate to events during the general anesthetic period. Some of these related to conversation in the operating room. Others involved sensory stimulation of surgery involving pain. Some involved feeling the surgeon working, but without pain, anxiety, or unpleasantness. It was also evident from our findings that some patients recounting such recall regarded hearing voices or conversation (even though they felt nothing) as being most unpleasant, while others found such auditory experiences not at all unpleasant. Similarly patients who related feeling surgical manipulations varied in their evaluation of this experience as unpleasant or not. The types of recall and whether that recall was unpleasant or distressful to the patient are presented in Table I.

In reviewing management of these cases in which recall occurred, there was but one factor which stood out on statistical analysis as being significantly different from the cases without recall. One particular anesthesiologist was involved in a disproportionately large number of these cases, and it was this physician's habit to talk extensively with his patients, even though they were anesthetized. Reports in the literature lend credence to the thesis that this auditory stimulation might act to arouse reaction in the patient during[10] or after[11] surgical exposure under general anesthesia.

Other reports indicate that the mental condition of the patient before anesthesia may be an important factor in determining the likelihood of recall. J. T. Brunn was able to give a highly accurate description of events during a fifty-five-minute general anesthesia he underwent for oral surgery. Two hundred fifty milligrams of Pentothal Sodium,® (Abbot Laboratories), was used for induction with another 200 milligrams administered during the case, along with 650 milligrams of Anectine,® (Burroughs Wellcome), and 80 percent nitrous oxide and oxygen. But he had deliberately motivated himself in advance to remember as much as possible of what transpired during his anesthetic exposure.[12] One of the cases of recall elicited during our study involved a similar state of mental expectancy, produced in the following manner:

A white female in her mid 20's became particularly interested in the details related to her anesthesia for an emergency dilatation and curettage for an incomplete abortion. During the explanation of the anesthetic procedure at the time of preoperative evaluation, the possibility of recall was discussed and she readily agreed to try to remember all she possibly could immediately before, during, and after the administration of anesthesia. General anesthesia was induced with 250 milligrams of Pentothal Sodium administered intravenously and maintained with 75 percent nitrous oxide and oxygen and a circle system with a total flow to the circle of 10 liters/minute. An additional dose of 75 milligrams of Pentothal was given intravenously immediately preceding the curettage. There was no movement, phonation, or grimacing at anytime after the induction during surgery. Twenty minutes after induction, the procedure was completed. Before turning off the nitrous oxide with the patient apparently still anesthetized, I dropped an empty wash basin from a height of about five feet above the operating room floor (terrazo). After recovery from her anesthesia, the patient recalled on questioning a vague memory of having heard "a loud noise, like a gong or something."

It appears that events are more

TABLE I

Recall Under General Anesthesia

Recall	A	B	C	D	E	F	G
Auditory	Yes	Yes	Yes	Yes	Yes	Yes	No
Pain	No	No	Yes	No	Yes	No	No
Sensory	No	Yes	Yes	Yes	Yes	Yes	Yes
Unpleasant	No	Yes	Yes	No	No	Yes	No

likely to be recorded in memory if they bear great emotional significance to the patient, either real or imagined. Eight out of ten patients deliberately exposed by B. W. Levinson[13] to conversation during their anesthesia (deep ether), indicating (falsely) a life-threatening crisis, revealed under age regression hypnosis after discharge that they heard and reacted to the information. Four of them repeated the alarming words of the anesthetist almost verbatim. Like the hypnotized patient, the anesthetized patient's critical judgment is impaired. Heard conversations may be misinterpreted or misapplied. Remarks in the operating room about a patient on one of the nursing units may be interpreted by the anesthetized patient as referring to himself or herself. Similarly the apparently comatose patient in an intensive care bed may be capable of unsuspected hearing and take remarks made about a patient in the next bed as pertinent to his own condition. The possibility of frightening a patient in this manner is real and recognized in clinical practice—by an unfortunate minority of physicians and nurses. Richard L. Kennan[14] states that "nitrous oxide in a concentration of 70 percent does prevent memory totally and in all patients." While this amnesia is maintained in most patients, it appears that the rare patient with some advance motivation to remember or the patient who hears something of great emotional significance may retain a memory trace.

Discussion

Reception of sensory events and imprinting of them in the memory while under general anesthesia may result in memories which are available later for spontaneous recall (Type I) or recall with the aid of age-regressive hypnotic techniques (Type II). A technician administering anesthesia might be concerned only about the former type since this might result in directed unfavorable patient reactions involving criticism, anger, or even lawsuits. As physicians we must also concern ourselves with Type II recall and seek answers to some questions:

1. What pharmacologic management will prevent both Type I and Type II recall?

2. What are the undesirable effects and results of Type II recall or Type II memories, if any, even though not recalled? (There are under investigation now new drugs which prevent Type I recall. If they do not abolish Type II recall as well, might unconscious but harsh memories adversely affect the patient's mental or physical health?)

3. How can we better educate anesthesiologists, nurse anesthetists, surgeons, operating room nurses, intensive care unit nurses, aides, and others caring for anesthetized or other depressed patients to guard their conversation?

Some answers and doubtless many more questions will come when enough of us are aware of and interested in the problem. This article is submitted to promote this end as well as to improve clinical management and patient comfort. □

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continuing education

This issue carries no education course listings. The September issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Pennsylvania Medical Continuing Education Institute, 20 Erford Rd., Lemoyne, PA 17043.

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Medical education: II

The Flexner Report in perspective today

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A MAJOR milestone in American medicine was the movement for reform started at the turn of the century by the Committee on Medical Education of the American Medical Association and the subsequent publication of the Flexner Report. Basically this report was provoked by the chaotic situation that then existed in the training of physicians in the United States. Many medical schools operated with little supervision, and some had actually degenerated into diploma mills. One of the fundamental objectives of the AMA's Committee on Medical Education and the Flexner Report was to rectify this situation and place the training of physicians on a sounder professional and scientific footing.

Their basic tenets were that medicine would have to embody the great scientific advances that were taking place in the physical and the biological sciences and that the humanities and science are not incompatible or contradictory in their aims. It became clear that the enormous contributions being made in microbiology, physiology, biochemistry and pharmacology (among other fields) would have tremendous inpact on the future practice of medicine. The belief was expressed that the scientific approach, which was proving so successful in the physical sciences, could be applied to medicine and that henceforth medicine could be practiced on a scientic rather than an empirical basis.

Accordingly, basic sciences were introduced into our medical schools and the classic four-year medical curriculum developed, divided into two years of basic science and two years of clinical training. This fundamental and standardized format existed virtually unchanged in all medical schools until 1952 when Western Reserve University, through the support of the Commonwealth Fund, developed an integrated curriculum. They did not, however, alter the administrative structure of the departments.[1, 2]

Following World War II, with the establishment of the National Institutes of Health, vast sums of money were allocated for the support of basic investigation. Strong basic science departments evolved in nearly all of the medical schools, and the resulting departmental structure of the schools has had important consequences. This basic research philosophy greatly influenced the development of the clinical departments. The pattern was established that in order to advance up the academic ladder in the clinical departments, a physician would first have to demonstrate expertise in some area of basic investigation. In addition, the clinical departments, particularly those of internal medicine, developed their own basic science faculties which frequently were in research competition with the faculties of the basic science departments — an unfortunate duplication of personnel. This was possible because of the great autonomy of the departmental chairmen and the failure of the deans to provide academic and administrative leadership because of their laissez-faire attitudes. Specifically, the deans failed to enforce the university concept of a cooperative approach among all departments, relating the expertise of the various components of the school to the total effort and objectives of the institution. With research support by the federal government being allocated to individual investigators and departments rather than as grants to the institution, the departments became stronger and stronger, primarily on the basis of federal support.

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The role of the practicing clinician was downgraded. Prestige rested with the research-oriented physician, and it was this type of physician who frequently became chairman of a clinical department, thus reinforcing the system. Unfortunately, many of these professors viewed patients primarily from the vantage point of an exercise in either physiology or biochemistry rather than from the viewpoint that here was a sick human being with a multiplicity of both physical and emotional problems. Patient care was downgraded and therapeutics ignored. The situation has been greatly aggravated by the Ph.D. training programs of the National Institutes of Health. All too frequently the granting of the degree was based on the development of students with great proficiency in highly restricted technology and not on a broad-based training in medicine. Thus, with reduction in research support, these individuals found themselves like a fish out of water, being quite insecure in their ability to participate in medical education and the teaching of medical students oriented to human pathophysiology and patient care.

Simultaneously there occurred

tremendous specialization and subspecialization of all major clinical areas. For example, in every first-rate department of medicine there emerged subspecialty divisions such as hematology, renology, gastroenterology, cardiology, and so on. Similar subspecialization occurred in surgery. As more sophisticated laboratory techniques were developed, physicians were trained more carefully and intensively in basic science approaches, and these subspecialists became capable of teaching their area of basic science to medical school students.

Certainly no one can argue the physiologic importance of cardiac catheterization in the understanding of cardiac function. The same can be said for renal dialysis and renal function studies. Similar conclusions can be drawn in regard to hematology, with the advent of sophisticated biochemical techniques, hemoglobin electrophoresis, and radioactive isotope methodology in the diagnosis of hematologic disease. As a result, a great overlap has developed between basic science departments and clinical departments, and students have begun to ask more and more for a better correlation between these two areas in the medical school.

Recent Developments

A new phase has now emerged in American medicine. The American people have become somewhat disillusioned with the applicability of our research efforts. The major reason for this disillusionment has been the tremendous gap that has developed between our expertise in research and the delivery of health care to all of the people in the United States. There is a deficiency of physicians in this country; but even more important, there is also a serious maldistribution. Increasingly demands are being made in the United States Congress for the training of more physicians and paramedical personnel. We have spent billions on research and have led the world in scientific advances, but still American medicine lags behind that of Western Europe and even Eastern Europe in the delivery of health care services to many of the people, especially the citizens from the lower economic strata in our large cities and remote rural areas. Therefore, the United States Congress and many important officials in the National Institutes of Health have charged the medical schools with the task of emphasizing once again the importance of health care delivery.

Research funds have been sharply curtailed. The medical school is being looked to, not just as a center for the training of physicians, but as a center for the development of new ideas and new concepts in the delivery of health care. This is particularly true of those medical schools located in urban environments, such as the Philadelphia schools. Great emphasis is being placed on group practice and regionalization of medical programs.

Another development has been the changing student attitude. With the growing social consciousness that is taking place in the United States, our students are demanding that more attention be given to the practice and delivery of health care. They are also demanding more correlated courses in the medical schools, with earlier exposure to clinical medicine. This has already led to major changes in curriculum. In the medical schools throughout the country, the old lockstep system of two years of basic science and two years of clinical medicine has been replaced by alterations in the curriculum, e.g., the core curriculum and the multitrack system such as the one at Hahnemann. Jefferson now has an accelerated program whereby a student may obtain an M.D. degree in five years after high school. A number of other institutions such as John Hopkins in Baltimore and Boston University are experimenting with a six-year program. This certainly appears to be the trend. Many medical schools

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are combining certain areas of basic science with clinical departments.

It is apparent that in keeping with the changes in the undergraduate curriculum, we must also move toward a better system of postgraduate education of our physicians. Storey[3] has reviewed the tightly regulated system of postgraduate education in the Soviet Union. Obviously such a program may be difficult to implement in a democratic society. However, in the United States, although some schools have been active in the field of broad-spectrum continuing education, much remains to be done. The Pennsylvania Medical Society, by establishing the Institute for Continuing Education, is also assuming leadership in an attempt to develop and coordinate educational programs for physicians throughout the state.

Coordinated Effort Needed

It is quite obvious that American medical education is now in a state of great flux. We must be more cognizant of the demands of the community and its needs in regard to medical care and health delivery. We must begin to think in terms of the group practice of medicine and regionalization of medical care. We must be cognizant of the needs of our students and the need to create more programs of ongoing postgraduate education and re-evaluation for our graduate physicians.

Does this mean that the basic sciences should be completely deemphasized in the medical schools? That point is being actively debated.[4,5,6] In our opinion, such a trend may have grave pitfalls and would merely indicate a disasterous swing of the pendulum to a point that existed prior to the appearance of the Flexner Report. Basic science and research should continue to be the soul of the practice of medicine. Medicine still does not have the definitive answers to most of the diseases that afflict mankind. In order to obtain these answers, one must depend upon basic science and upon the many Ph.D.s and M.D.s who are adequately trained in basic research.

It would appear that the exact departmental structure is not as critical as the overall organization and policies regulating interdepartmental relations. The department must be subservient to the overall organization and must sacrifice significant professional territorialism for the overall good of the institution. If this is not done, the basis of the university concept is lost, and we end up with a series of independent fragmented units within a shell, but without internal structure. A strong centralized administration is essential, an administration which takes leadership and can thus coordinate the total operation and numerous interdepartmental academic efforts—thus increasing academic proficiency and avoiding overlap and duplication of effort and personnel. This requires top quality, academically oriented, administrative leaders and not men oriented to business alone. Each department in turn should accept responsibility for all professional activities and programs within the corporate structure—whether this be clinical or laboratory oriented. This in itself will help guide the general programs in the direction of relevancy and will minimize the breach between the so-called basic sciences (laboratory sciences) and clinical sciences; between the Ph.D. and the M.D. faculty and many other organizational units which tend to become isolated and unresponsive to the social trends of the time.

In brief, what is required is an honest and careful amalgamation of the basic sciences and their research efforts with the clinical departments through strong and centralized academic leadership in our medical schools and universities in order to establish efficient research and student training programs. This can only be accomplished by sound, centralized executive direction of our academic institutions. These efforts can then be translated not only into coordinated medical care, but also into the training of cadres of physicians and scientists who will remain within academic medicine and will attempt to advance the frontiers of medical science.

An increasing number of universities are implementing their efforts to integrate the basic and clinical sciences by creating a strong chief academic officer, i.e., a vice president who is charged with the responsibility of coordinating all academic activities related to health care that are represented in the numerous schools and colleges in the university complex. It is apparent that a dean of the medical school alone, as defined in classic terms, can no longer coordinate the activities of the Graduate School of Medical Sciences, the College of Allied Health Sciences, the School of Continuing Education, the Dental School, and other colleges and departments to be created in the medical schools in the future. Rather, the deans of these various schools should report directly to the vice president in charge of academic affairs, who will then coordinate their individual efforts. It is apparent that if the schools are to advance in these decisive times, close coordination must be achieved among their educational endeavors. Such an approach would give every institution its best chance of having a major impact, not only in the education of medical students, but also in the whole problem of the delivery of health care throughout the country. No person or institution can remain an island unto itself. Academic medicine is universally supported by the tax-paying citizen. Therefore, we must listen to our constructive critics if the growth, viability, and stability of our medical institutions and the needs of our students, patients, and community are to be met. □

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Special Report

Manipulating the Pennsylvania spine

ROBERT L. LAMB
Director of Communications

The 1,000 licensed chiropractors in Pennsylvania have taken a fundamental nursing procedure, the back rub, and parlayed it into a gold mine by stroking away the tensions and anxieties of modern life. And what they lack in scientific knowledge, they make up for in business acumen.

Within the last twelve months, Pennsylvania chiropractors have unsuccessfully attempted to extend their practices by offering acupuncture, attempting to use hospital laboratories and x-ray departments, attempting to give spinal examinations in public schools, and seeking to administer drivers' physical examinations.

As early as two years ago chiropractors were attempting to submit specimens to hospital laboratories and to obtain test results. One such instance occurred at a hospital in Montgomery County and another in southwestern Pennsylvania. The cases were referred to the Society's legal counsel who held that it is unethical for a medical doctor to accept specimens from chiropractors and perhaps even illegal. Does, for example, a physician who provides laboratory reports to a chiropractor aid and abet the unlawful practice of medicine?

Under the final regulations of the Clinical Laboratory Act as published in the *Pennsylvania Bulletin* on June 15, the question of who may submit specimens to a clinical laboratory is open to interpretation. The Society had hoped to pin it down to doctors of medicine and of osteopathy. In this regard it received the support of the Hospital Association of Pennsylvania. The rules, however (Section 5.41), state:

> "Specimens shall be accepted from patients by a clinical laboratory only when tests are requested on such specimens by a member of the healing arts licensed to practice in Pennsylvania, or other person authorized by law, or authorized agents of the foregoing."

There is also a reporting requirement which says:

> "Reports of clinical laboratory findings shall be made only to the person submitting the specimen or requesting the analysis, or his authorized agent."

This language does not require that any laboratory or physician *must* accept a specimen from a chiropractor. However, once a specimen is accepted, the information must be released to the referring source.

Hospital physicians have held firm in denying services to chiropractors and have been backed by their hospitals.

On May 24, the Hospital Association of Pennsylvania urged "member institutions to honor requests for diagnostic and treatment services of only those professional individuals whose qualifications meet the requirements for admission to the hospital staff as provided by the hospital's bylaws."

Present hospital licensing laws require that staff privileges be granted only to physicians who hold an unrestricted license to practice medicine and surgery in the Commonwealth. The standards of the Joint Commission on Accreditation of Hospitals also require that medical staff membership go to individuals who are fully licensed to practice medicine.

In Pennsylvania, the difference between chiropractic practice and the practice of medicine has been established by both statute and judicial decision. The new Medical Practice Act (Act 190) defines the term, medicine and surgery, as: ". . . the art and science having for its object the cure of the diseases of and the preservation of the health of man including all practice of the healing art with or without drugs, except healing by spiritual means or prayer."

The General Assembly has defined chiropractic as "a limited science of the healing art," including only "chiropractic diagnosis" and only "limited treatment without the use of either drugs or surgery."

In the early 1960s, Pennsylvania chiropractors challenged this definition by attempting to do physical examinations for those applying for motor vehicle operator licenses. In a resultant court case *(Howe v. Smith)* the Pennsylvania Superior Court considered both the Medical Practice Act and the Chiropractic Registration Act and underscored the differences.

In deciding the issue against chiropractors, Commonwealth Court said: "Only licensed physicians have the statuatory authority to diagnose diseases, and that determining mental disabilities and diagnosing diseases are in the areas that are prohibited to the practice of chiropractic."

The Superior Court confirmed the action of the Commonwealth Court and said . . . "The validity of the prohibition against chiropractors practicing medicine is not and cannot be denied."

The chiropractors admitted that their right to treat diseases was limited but said they were not limited in their diagnosis. The court agreed that the legislature had failed to spell out as clearly as it "could have and should have" the limits of chiropractic diagnosis but said that "such direction should be obtained from the legislature rather than asking the courts to confer unlimited diagnostic authority on chiropractors through a "strained construction of the statutes."

The Pennsylvania Superior Court concluded the case

by stating: "Naturally the chiropractors would like to be equated with the medical profession, but neither their recognized field of practice nor the statutes relating to these professions makes such an equation realistic. Chiropractors are engaged in a limited field of the healing arts which requires less education and training of them than is required of those practicing medicine and surgery."

A year later, the Pennsylvania General Assembly amended the definition of chiropractic as follows: ". . . a limited science of the healing arts dealing with the relationship between the articulations of the vertebral column as well as other articulations, and the nervous system and the role of these relationships in the restoration and maintenance of health. It shall include *chiropractic diagnosis*."

Thus the legislature acknowledged that chiropractic is limited and that the only permissible diagnosis available to chiropractors is "chiropractic diagnosis."

The latest chapter in the quest by chiropractors to give prospective drivers physical examinations occurred August 7, 1974, when the Department of Transportation, at the request of the Pennsylvania Chiropractic Society, held a hearing on the subject. Stephen J. Barrett, M.D., Allentown, a member of the Society's Committee on Quackery testified. He said, "I would like to begin by stating in the strongest terms possible that this proposal is extremely dangerous to public health and safety." Dr. Barrett said: "I submit that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human diseases. In fact, each and every scientifically based, objective study on chiropractic including those by numerous federal and state governmental agencies, has concluded that chiropractors are incapable of performing proper diagnosis which is a major requirement of a physical examination."

As more and more Americans visited China, the American public showed an interest in the ancient oriental art of acupuncture. While the American medical community viewed acupuncture with great caution, chiropractors saw it as another means of building business. During 1973 an increasing number of reports appeared that chiropractors in Pennsylvania were using acupuncture, although scientific study of acupuncture is still in the early stages.

Of primary importance, however, is the question of whether or not acupuncture is the practice of medicine. In 1973 the State Board of Medical Education and Licensure declared it has jurisdiction, and said: "In Pennsylvania this procedure, 'acupuncture,' has not been researched nor proven beneficial. It is the Board's opinion that patients who have been properly examined and diagnosed and considered for acupuncture could receive same after referral by a physician to a research setting in a medical school under the guidance of a duly licensed and registered physician in the Commonwealth."

In March, Louis P. Vitti, newly appointed commissioner of professional and occupational affairs, held a series of three hearings across the Commonwealth on acupuncture. Conspicuous by their absence from the hearings were consumers. Conspicuous by their presence were chiropractors. And although the "mixers," those chiropractors who include vitamin therapy, nutrition regimens, and other health fads in their armamentarium, were very desirous of including acupuncture, their fundamentalist brethren, the "straights," would have no part of it.

An important milestone was passed on Saturday, July 23, 1974, when Attorney General Israel Packel issued his opinion (No. 39) to Commissioner Vitti on the subject of acupuncture. The Attorney General said: "Of all health care practitioners, only two, doctors of medicine and osteopathy, are authorized to pursue an unlimited practice of the healing arts. It is clear that the use of acupuncture falls within the purview of the law quoted above (Medical Practice Act) and therefore may be practiced by doctors of medicine. The State Board of Medical Education and Licensure which regulates the practice of medicine must regulate the practice of acupuncture insofar as it relates to its licensees."

The Attorney General stated: "Since osteopaths, like physicians and surgeons, are authorized to pursue an unlimited practice of the healing arts, they too can practice acupuncture with only those limitations imposed by the State Board of Osteopathic Examiners."

The opinion permits dentists and podiatrists to practice limited acupuncture within the confines of their licensing act. Veterinarians are also permitted to practice acupuncture.

Since the optometric act does not permit optometrists to "cure diseases or relieve pain," which is the basic purpose of acupuncture, the attorney general's opinion rules that optometrists are not permitted to engage in the practice of acupuncture.

In dealing with chiropractors and acupuncture, the Attorney General noted the *Howe v. Smith* case and the limited nature of chiropractic science which is concerned with the relationship between articulations of the vertebral column and other articulations as they relate to the nervous system. He concluded: "From a careful reading of the definition of the chiropractic, from an understanding of the basic philosophy of the chiropractic as well as from the reasons discussed previously, it seems clear that to permit chiropractors to insert needles into various parts of the human body to cure disease, as acupuncture requires, would be an over-extension of his or her profession. We, therefore, conclude that chiropractors may not practice acupuncture."

Meanwhile, the State Society supports House Bill 2314 which seeks to control acupuncture and to prohibit the performance of acupuncture by a person who is not a licensed physician. The bill reads:

> "The performance of acupuncture for the purpose of demonstration, therapy, or the induction of analgesia by a person who is not a physician licensed under this act is not a violation of this act if the acupuncture is performed under the supervision and control of a physician licensed under this act. The Board shall determine the qualifications of a person authorized to perform acupuncture under this paragraph. Records of the diagnosis, treat-

ment, and patient response to acupuncture shall be maintained and submitted upon request to the State Board of Medical Education and Licensure. As used in this paragraph, "acupuncture" means the selective stimulation of the body's neurological and defense mechanisms by the insertion of needles in an effort to correct neuro-muscular and organic disorders or to induce analgesia."

In the fall of 1973 the president of a joint school board in western Pennsylvania received a letter from a local chiropractor pointing out that Governor Shapp would designate October as "Spinal Health Month" and that in observance of this the chiropractors of the area would "appreciate the opportunity to utilize some of this time in conducting spinal checkups for all the students of your schools or for the classes or individuals, you, the school officials, or parents would like included in the program.

"This examination will include a complete check of the student's spine, their nervous system, posture, and physical development and will work toward the early detection and correction of spinal disorders and distortions, thus helping to avert many health problems. A report would be furnished to each child," the letter said.

The letter also sought permission to send a pamphlet entitled "What Parents Should Know About The Spine" home with all of the children in the first, second, and third grades. The service was to be free of charge to the school district.

The State Society received an opinion from the Department of Health that the spinal checkups by chiropractors "could not be incorporated into the mandated school health program in which medical examinations must be performed by physicians legally qualified in this state." The school board stood its ground and refused to permit the chiropractic examinations.

In April, the Society received word that a school district in the northeastern part of Pennsylvania did give permission to a chiropractor to examine students at the public school.

The Society's legal counsel, Fred Speaker, cited the Public School Code (24 P.S., Sections 1-101, *etsequ*): "The school physicians of each district of joint boards shall make a medical examination and a comprehensive appraisal of the health of each child of school age. . ."

The school code, said Speaker, places the school physician directly within the framework of the public education institution and assigns him explicit duties. The code also defines the school physician as: "A physician legally qualified to practice medicine and surgery or osteopathy or osteopathic surgery in the Commonwealth, who has been appointed or approved by the Secretary of Health."

On August 9, 1974 HEW issued regulations relating to the coverage of chiropractic services under medicare. The final regulations limit coverage of chiropractic services to treatment by means of "manual manipulation of the spine to correct a subluxation demonstrated by X-ray to exist, which has resulted in a neuromusculoskeletal condition for which such manipulation is appropriate treatment" and which the chiropractor is legally authorized to perform. No reimbursement will be made to a chiropractor for X-rays or other diagnostic or therapeutic services. HEW also called for increased educational requirements for individuals studying chiropractic after June 30, 1974.

As chiropractors have increased their activities so has the State Society intensified its fight against chiropractors and all forms of quackery. A significant step was taken by the 1972 House with the creation of a Committee on Quackery. This was underscored a year later when the 1973 House authorized a voluntary Quackery Defense Fund. Members were asked as part of their 1974 billing for a $5.00 voluntary contribution to fight quackery. By mid-year that total had reached about $19,000. The Quackery Committee is conducting a vigorous campaign against chiropractors.

An idea of the task before it can be seen from an Associated Press story by Lee Linder, which appeared in papers across the state in late July. According to Linder "Governor Milton Shapp wants chiropractors to play a role in important state research of what he calls 'the most baffling diseases of our time, black lung and diabetes'."

The Governor made his request for chiropractic research into black lung and diabetes in a four-page memo to his health services director, Leonard Bachman, M.D., in February, Linder said.

The story quotes Dr. Bachman's response to the memo: "We can't explain many things in medicine. People get better for reasons we don't understand . . . the Governor is not a physician and I wouldn't want to get him way out on a limb, but I think it is a good idea, and I hope to get a research evaluation of the work of chiropractors, at least in the black lung. I don't know about diabetes."

While chiropractors remain highly critical of medical doctors, they nonetheless seek to annex the term "physician." Recently this enterprise received a setback when the Attorney General's Office, in a July 5, 1974 memorandum, determined that chiropractors may not use the term "physician."

Tilman Gerald, legal assistant, writing to the State Board of Chiropractic Examiners, said:

> "The question has arisen as to the permissibility of chiropractors using the term 'physician' in conjunction with his or her name or designation. Clearly, the answer is in the *negative*." (emphasis added)

Gerald went on to cite Steinbach et al. v. Metzger et al. 63 F 2d 7476 (1933) declaring, "The crux of the distinction is 'that the practice of chiropractic, though a healing art . . . has nothing in common with drugs, medicine or surgery . . .' whereas these are 'techniques of diagnosis which a physician may use that are denied by statute to a chiropractor.' Howe et al. v. Smith."

The Department of Justice memorandum concludes by stating:

> "Therefore, be advised that the use by chiropractors of the term 'physicians' in conjunction with his name or designation is statutorily impermissible."

trauma

Trauma index—evaluating injury victims

WILLIAM E. DeMUTH, JR., M.D.
Hershey

Emergency medical service is characterized by the involvement of nonphysicians more than any other area of clinical medicine. In caring for the injured, limitations of time require accurate communication to facilitate triage and to avoid wasting valuable time and facilities on trivial injuries to the detriment of those more seriously hurt. In addition, all physicians will recall instances where seriously injured patients have been discharged from the emergency room or were otherwise neglected because of missed diagnoses.

Ambulance attendants, nurses, and physicians in training would be helped by a system which helps to evaluate the relative importance of injuries when encountered singly or in combination. The sharp line between prehospital and hospital care is disappearing, fortunately, and care at the accident site and in the emergency room should be viewed as a continuum. Anything which might help to anticipate activity in the emergency room and the operating room will perforce improve care.

In 1971, Kirkpatrick and Youmans* described a "Trauma Index" which scored injured patients on a number of highly significant parameters. Of over sixty

* Kirkpatrick J. R., Youmans R. L.: Trauma Index: an aid in the evaluation of injury victims. J. Trauma 11:711, 1971.

ECU Trauma Index

Patient's Name _____

Date _____ **Age (if available)** _____

TRAUMA INDEX

	1	3	4	6
Region	Skin or Extremities	Back	Chest or Abdomen	Head or Neck
Type of Injury	Laceration or Contusion	Stab Wound	Blunt	Missile
C-V Status	External Hemorrhage	BP < 100 P > 100	BP < 80 P > 140	Absent Pulse
CNS Status	Drowsy	Stupor	Motor or Sensory Loss	Coma
Respiratory Status	Chest Pain	Dyspnea or Hemoptysis	Evidence of Aspiration	Apnea or Cyanosis

Total =

INTERPRETATION OF INDEX

Total Score	Conclusions
0 - 7	Minor injury—usually not requiring hospitalization
8 - 18	Moderately severe—injury requiring hospitalization
18 and up	Severe injuries—50% mortality

The numerical index is to be completed by ECU nurse in all cases of injury. When a total score of 7 or more is caluclated, the surgical resident on call should be called STAT. This form is to be Attached to ECU record.

Patient Admitted ☐

Patient Not Admitted ☐

variables evaluated, it was determined that a reliable decision could be based upon the region of the body involved, type of injury, cardiovascular, central nervous system, and respiratory status. Grades from one to six were applied in a progression based on severity. The "minimal" score is 1, with "moderate" scores being 3 and 4, and "severe" rated as 6.

Although not absolutely precise, the index probably has only a 5 percent or less margin of error. We did not analyze in detail our data on 2,700 patients tabulated, but we found that serious errors of oversight occurred only three times. Kirkpatrick and Youmans had ten errors out of 325 determinations in a more detailed study. In our experience, overscoring is more prevalent and obviously much less serious, and experience tends to lessen overestimations of severity of injury. One illustration is the presence of a scalp laceration (Score 7) associated with any other injury. This may result in an erroneously high score leading to unnecessary hospitalization. Long bone fractures and tendon injuries tend to result in low scores not reflecting the need for hospitalization in many instances. The index is not applicable to burns.

The index was designed for use at the accident site using available information. No patient cooperation is required, minimum equipment is required, and the information can be gathered by nonphysicians. It does not take the place of careful examination in the hospital emergency room. It is useful in triage and communication between those initially caring for the patient and the physician ultimately responsible for his care. The minor inconveniences caused by inaccuracies in the method overshadow the possible benefits accrued by guiding the nonphysician in this very important aspect of care. It provides assistance in auditing emergency room activity on a day-to-day basis.

This paper was prepared by the department of surgery of the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

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obituaries

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **Townsend W. Baer,** Pittsburgh; University of Pittsburgh School of Medicine, 1928; age 70; died August 25, 1974. He was an associate professor in the department of dermatology at the University of Pittsburgh Medical School and chief of dermatology at the Veterans Administration, Pittsburgh. Dr. Baer was a member of the American Academy of Dermatologists. He is survived by his wife, two daughters, and a brother.

• **Vincent W. Banick,** Wilkes-Barre; Jefferson Medical College, 1935; age 66; died August 6, 1974. He was chief of the department of ophthalmology at Wilkes-Barre General Hospital. He is survived by his wife, three daughters, a sister, and three brothers.

• **Galen D. Castlebury,** Williamsport; University of Pennsylvania School of Medicine, 1914; age 82; died July 15, 1974. He had practiced medicine in the Williamsport area for more than fifty years and was a past president of the Lycoming County Medical Society. He is survived by two sons and a daughter.

• **Luther H. Cone,** Paxinos; University of Kansas College of Medicine, 1931; age 67; died August 13, 1974. He was chief of surgery at Shamokin State Hospital and a member of the American College of Surgeons. He is survived by his wife and four sons.

• **Alexander C. Cohen,** Philadelphia; University of Pennsylvania School of Medicine, 1924; age 72; died August 24, 1974. He had practiced medicine for fifty years. Survivors include his wife and two sisters.

• **Stanley F. Druckenmiller,** Lansford; Medico-Chirurgical College, Philadelphia, 1910; age 89; died August 3, 1974. He had practiced medicine for more than sixty years. A daughter and a son survive him.

• **Joseph C. Griffith,** Monessen; Jefferson Medical College, 1927; age 74; died August 10, 1974. He was a member of the Association of American Physicians and Surgeons, the American Academy of General Practice (now the American Academy of Family Practice), and a past president of the Westmoreland County Medical Society. Survivors include his wife, a daughter, and a son.

• **John W. Kirschner,** Luzerne; University of Pennsylvania School of Medicine, 1905; age 92; died August 4, 1974. He is survived by a daughter.

• **Anna P. Klemmer,** Lititz; Woman's Medical College (now Medical College of Pennsylvania) 1926; age 73; died August 1, 1974. She was a fellow of the American College of Physicians and the American Academy of Pediatrics. She is survived by a son.

• **Walter P. Knight,** Scranton; University of Maryland School of Medicine, 1929; age 69; died August 19, 1974. He was former chief of the surgical staff at West Side Hospital and Community Medical Center and was a charter member of the American Academy of Family Physicians. He is survived by his wife, a son, a daughter, a sister, and two brothers.

• **Meyer Q. Lavell,** San Diego, California; Jefferson Medical College, 1928; age 73; died August 11, 1974. He had practiced medicine in Darby for thirty-seven years prior to his retirement. Dr. Lavell was cofounder of Doctors Hospital, Philadelphia, and cofounder of the American Geriatric Society. He is survived by his wife and a sister.

• **Raymond J. McGrath,** Philadelphia; Hahnemann Medical College, 1926; age 73; died August 2, 1974. He was a former clinical professor of otolaryngology at Hahnemann Medical College and Hospital. Survivors include his wife, a son, and a daughter.

• **George A. F. Moyer,** Shamokin; Jefferson Medical College, 1925; age 72; died August 16, 1974. He is survived by a daughter, Marilyn Moyer, M.D., Danville; and four sisters.

• **Jacob A. Ruben,** Pittsburgh; University of Pittsburgh School of Medicine, 1906; age 91; died August 16, 1974. He is survived by a son, J. Eugene Ruben, M.D., Phoenix; and two daughters.

• **Harold H. Sankey,** Pittsburgh; University of Pennsylvania School of Medicine, 1936; age 63; died August 13, 1974. He was a member of the American Academy of Orthopedic Surgeons, the Eastern Orthopedic Society, and was associate professor of orthopedics at the University of Pittsburgh School of Medicine. He is survived by his wife; two sons; a daughter; a sister; and a brother, B. Burdell Sankey, M.D., Cleveland, Ohio.

• **William A. Schmidt,** Shenandoah; University of Pennsylvania School of Medicine, 1923; age 78; died June 21, 1974. No further information is available.

• **Rendall R. Strawbridge,** Philadelphia; University of Pennsylvania School of Medicine, 1933; age 65; died July 28, 1974. He is survived by his wife, two sons, and three daughters.

Jacob Golove, Philadelphia; University of Pennsylvania School of Medicine, 1925; age 71; died July 27, 1974. His wife, two daughters, and three sisters survive him.

John N. Rich, Newtown; Hahnemann Medical College, 1925; age 80; died March 17, 1974. His wife survives him.

G. Philip Saxer, Glens Falls, N.Y.; age 100; died August 14, 1974. He had practiced medicine in Fleetville for over sixty years. He is survived by a son.

Everett A. Tyler, Philadelphia; Hahnemann Medical College, 1913; age 86; died August 9, 1974. He is survived by his wife, a son, and a daughter.

Edward R. Schlesinger, Pittsburgh; Columbia University College of Medicine; age 63; died August 21, 1974. He was head of the maternal and child health program at the University of Pittsburgh Graduate School of Public Health and associate dean for academic affairs. He is survived by his wife; a daughter; and a son, Stephen Schlesinger, M.D., Philadelphia.

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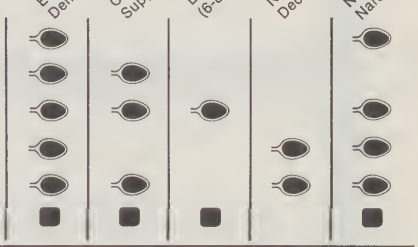

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ANNUAL REPORT

Pennsylvania Medical Care Foundation (PMCF)

In accordance with ARTICLE XII - MISCELLANEOUS, *Section 3. Annual Report,* of the Bylaws of the Pennsylvania Medical Care Foundation, this report is being submitted for consideration by the Administrative Members of the Foundation.

ORGANIZATION

I. Board of Directors

Following the October 1973 meeting of the Administrative Members, the Foundation's Board of Directors met and elected the following officers: President - Matthew Marshall, Jr., M.D.; Vice President - Henry H. Fetterman, M.D.; Secretary - Mr. Vincent Lechner; and Treasurer - Mr. John F. Rineman. The Board also elected an Executive Committee and appointed Mr. Larry R. Fosselman as the Foundation's Executive Director. A roster of the Foundation's Board of Directors is attached (Appendix A).

II. Board Committees

In addition to the Executive Committee, the Board of Directors appointed a Committee on Quality Appraisal and a PSRO Development Committee.

The Committee on Quality Appraisal is responsible for the Foundation's Inpatient Quality Appraisal Project (IQAP) and for assisting hospital medical staffs and PSROs in developing medical audit procedures and methods for evaluating their effectiveness.

The PSRO Development Committee, which is composed of PSRO Chairmen, is responsible for: (a) providing advice to the Board on PSRO rules and regulations; (b) recommending methods for PSRO implementation; and (c) providing a forum for PSRO Chairmen to exchange ideas and discuss common problems.

III. Administrative Staff

The following staff positions were created in addition to the position of Executive Director: Director of Systems Design and Research - vacant; Coordinator of Field Services - Mr. William F. S. Orner, Jr.; Administrative Assistant - Mrs. Dale Yates; Western Pennsylvania Field Representative - Mrs. Rose Ferraro; Central Pennsylvania Field Representative - Mr. Carmine Striano; Eastern Pennsylvania Field Representative - vacant. Four (4) secretarial positions were created to support the executive staff.

The Board of Directors also retained the following consultants: Chief Consultant on Quality Appraisal Systems - David J. Jones, M.D.; Consultant on Quality Appraisal - Joseph S. Gonnella, M.D.; and Consultant on Evaluation - Kenneth Rodgers, M.D.

FINANCIAL REPORT

Effective January 1, 1974, the PMS Board of Trustees authorized the transfer of the assets and liabilities of the PMS Medical Care Appraisal Project (MCAP) to the Foundation. The auditor's report on the MCAP is attached (Appendix B) for the periods ending December 31, 1973 (12 months) and December 31, 1972 (18 months).

During fiscal year 1974 (January 1, 1974 - December 31, 1974) the Foundation will receive funding from the Pennsylvania Medical Society in the amount of $28,803 which is a revised allocation of the $100,000 authorized by the Board of Trustees based on the October 1973 House of Delegates action.

Other sources of funding include the Susquehanna Valley Regional Medical Program ($9,936 grant for period of 1/1/74 to 6/30/74) and the U.S. Department of Health, Education, and Welfare ($243,295 contract for the period of 3/29/74 to 3/28/75).

The attached (Appendix C) Statement of INCOME AND EXPENSES outlines the Foundation's financial condition as of August 31, 1974.

The Board of Directors recognizes the uncertainty and reduced flexibility created by federal funding and realizes that other sources of funding will be necessary to carry out functions outside the Support Center Contract. Also, the Board must be prepared to seek other support to perform functions mandated by the PMS House of Delegates in the event the HEW Contract is not extended.

At the time of this report, the PMS Finance Committee was considering a Foundation request for PMS funding in the amount of $9,897 for 1975 to cover expenses outside the HEW Contract.

PSRO ACTIVITIES

The Foundation has devoted a considerable amount of its effort, over the past year, on the following PSRO activities. The primary area of activi-

ty during the coming year will also center on PSRO development.

I. PSRO Area Designations

As was reported at the 1973 Annual Meeting, the PMS Board of Trustees directed the Foundation in August 1973 to assume the responsibility for assisting county medical societies, where appropriate, and HEW in the development of PSRO area designations for Pennsylvania.

In order to determine county medical society PSRO area preferences the Foundation conducted surveys of the county societies, held regional meetings of County Medical Societies and testified at two (2) HEW hearings on area designations. Based on the advice and guidance received from County Medical Societies, the Foundation recommended twelve (12) PSRO areas which were subsequently approved by the Secretary of HEW.

II. Statewide PSRO Support Center

At the June 1973 Special Session of the PMS House of Delegates, the following actions were taken regarding the role of the Pennsylvania Medical Care Foundation in PSRO activities:

A. The House of Delegates designated the Pennsylvania Medical Care Foundation as the official organization responsible for assisting in an advisory capacity in the implementation of the Bennett Amendment in Pennsylvania.

B. The House of Delegates directed the Pennsylvania Medical Care Foundation to assume the following responsibilities:

1. Advise in the development and revision of medical care criteria through the Council on Medical Service's Specialty Advisory Committees and/or the appropriate state specialty society.
2. Facilitate the research, development and testing of peer review systems and procedures necessary for local units to comply with the provisions of the Bennett Amendment.
3. Provide assistance to county medical societies or groups of county medical societies in establishing the organizational format and operational procedures for locally operated peer review programs.
4. Aid in the development of the managerial structure and make available consultative administrative personnel necessary for the effective operation and coordination of local units.

Based on these actions, Senator Wallace Bennett issued a statement outlining the areas of responsibility in PSRO implementation that could be assumed by statewide professional organizations, such as a medical care foundation. HEW subsequently adopted a similar position. As a result of these activities, the PSRO Support Center concept evolved.

At the same time, during the fall of 1973 and the early part of 1974, the Foundation submitted several proposals to HEW requesting funding to implement the June 1973 directives of the PMS House of Delegates. Finally, On March 29, 1974 the Foundation was awarded a twelve (12) month contract in the amount of $243,295 to operate a PSRO Support Center for Pennsylvania.

As a statewide PSRO Support Center, the Foundation is responsible for assisting and advising PSROs in matters related to organizational structure, administrative structure and procedures, providing information and advice on peer review procedures and in general providing whatever assistance is necessary for the local PSROs to qualify for conditional (operational) approval by HEW. In addition, the Support Center is directed to assist hospital medical staffs in the organization and operation of peer review programs necessary to meet present Medicare and Medicaid requirements.

Appendix D is a progress report which outlines the Foundation's activities in fulfilling the requirements of the HEW contract.

During the coming year the Foundation will devote a considerable amount of time to the following Support Center activities which will be developed in consultation with the local PSROs:

- Update address listings of physicians for each PSRO area.
- Act in a liaison capacity between the local PSROs and DPW, BHI, fiscal intermediaries, HUP, and PAS.
- Provide consultative services, at the request of local PSROs, for providers or the PSRO in the areas of utilization review, medical care evaluation, etc.
- Conduct training seminars and workshops for PSRO personnel in administrative, technical, and medical areas.
- Act as the focal point for collection of the health data statistics needed by the twelve (12) PSROs in the state.
- Develop and test and conduct research in improving medical audit techniques.
- Offer assistance in the organization of the State Professional Standards Review Council.
- Assist PSROs in preparing and presenting conditional contract proposals.

III. Local PSRO Development

During the spring of this year HEW released Requests for Proposals (RFP) for two (2) types of local PSRO contracts. The first type of contract is

termed conditional. A conditional contract requires that the applicant organization demonstrate a capability of conducting peer review programs required by the Law and that at least twenty-five (25) percent of the physicians in the area are members of the organization.

The second type of contract is for planning and is just that. It provides funds for a prospective PSRO to plan and organize a PSRO that will then qualify for a conditional contract.

In Pennsylvania, county medical societies in eight (8) of the PSRO areas formed organizations which submitted planning contract proposals. The following is a listing of the PSROs which were funded by HEW effective on or about July 1, 1974 to carry out 6-month planning contracts:

PSRO	Area	Amount of Contract
Central Pennsylvania Area II PSRO (Williamsport)	II	$ 41,175
Eastern Pennsylvania Health Care Foundation (Allentown)	IV	$ 65,000
Allegheny PSRO (Pittsburgh)	VI	$ 88,217
Southwestern Pennsylvania PSRO (Greensburg)	VII	$ 62,500
Highlands PSRO Corporation (Johnstown)	VIII	$ 46,600
South Central Pennsylvania PSRO (Harrisburg)	IX	$ 54,000
Montgomery/Bucks PSRO (Norristown)	XI	$ 54,000
Philadelphia PSRO	XII	$100,000

Appendix E is a roster of PSRO Chairmen and Project Directors.

The Foundation assisted the county medical societies in getting PSRO Steering Committees organized in six (6) of the areas and provided technical assistance, and in some cases direct staff support, to all eight (8) PSROs in preparing their proposals to HEW.

During the past summer the foundation also assisted in organizing PSRO Steering Committees in Area I (Erie), Area III (Scranton/Wilkes-Barre), and Area V (Sharon/Clearfield). The delay and uncertainty of HEW funding has prevented these three (3) areas from submitting their planning proposals.

IV. HEW PSRO Contracts

On a nationwide basis, HEW awarded 115 PSRO contracts totaling $20,850,318 as of July 1, 1974. These involved contracts for 13 support centers, 11 conditional PSROs and 91 planning contracts.

FOUNDATION PROGRAMS

While the Foundation has devoted a considerable amount of time to carrying out specific responsibilities as a Support Center, the following activities, instituted prior to the Support Center Contract, have been continued.

I. Certified Hospital Admissions Monitoring Program (CHAMP)

Following the Foundation's efforts over the past two (2) years, the Department of Public Welfare (DPW) agreed to allow hospitals to operate their own in-house utilization review program in lieu of participating in the DPW PreDischarge Utilization Review (PDUR) Program. DPW took action requiring all hospitals (treating Medicaid recipients) to have a concurrent utilization review program by October 1, 1974. DPW agreed that hospitals could use the Foundation's CHAMP system as an alternative to PDUR by notifying the Department that the CHAMP system would be implemented in accordance with the CHAMP Procedural Manual which was distributed to all hospitals in July 1974. The CHAMP system was revised to meet all the requirements set forth in the HEW PSRO Manual.

As of September, 1974, forty-one (41) hospitals had notified DPW that they would use the CHAMP system instead of PDUR.

II. Inpatient Quality Appraisal Project (IQAP)

The Foundation continued the activities of the IQAP to develop an effective method for hospital medical staffs to carry out quality appraisal responsibilities which will reduce the unnecessary and unproductive use of physician manpower.

The experience of the IQAP indicates that there are many problems in developing an effective, objective system for identifying areas of medical practice that warrant peer review.

The Foundation intends to pursue the IQAP objectives so that hospital medical staffs will have a simple method for evaluating the quality of care that is consistent with professional standards and will meet the JCAH and PSRO requirements. The Foundation will also assist PSROs in developing a system for evaluating the effectiveness of each hospital's quality appraisal program.

III. OTHER FOUNDATION ACTIVITIES AND ACTIONS

The following is a summary of Foundation activities and actions not otherwise mentioned in this report:

1. Requested the Health Insurance Council to appoint a representative to attend Board meetings as an observer.
2. Developed a policy on specialty society representation in foundation activities; invited the

Chairman of the PMS Interspecialty Committee to attend all Board meetings.

3. Elected a representative of the Pennsylvania Dental Association to the Board.
4. Cosponsored Utilization Review and Quality Appraisal Seminars with HUP and Blue Cross.
5. Objected to HEW proposed regulations requiring preadmission certification for Medicare and Medicaid hospital admissions.
6. Sent letters to Pennsylvania's Congressional Delegation explaining PMS-PMCF position on Bennett Amendment and PSRO implementation.
7. Adopted a policy statement on reimbursement for persons involved in PSRO activities.
8. Objected to a Pennsylvania Department of Health proposal to establish a statewide peer review system operated by the Health Department.
9. Approved continued distribution of the PMS Criteria for Inpatient Medical Care Manual.
10. Presented testimony at the May 9, 1974 oversight hearings conducted by the U.S. Senate Finance Committee.

BYLAWS

During the past year, the Board reviewed the Bylaws on several occasions. The Board agreed that certain changes should be made in the Bylaws to improve clarity and to meet present needs and circumstances.

The Board approved changes in the Bylaws which are presented in Appendix F for consideration by the Administrative Members. (The words or phrases in brackets are deletions and the underlined sections are additions).

Recommendation

The Board of Directors of the Pennsylvania Medical Care Foundation recommends that the Administrative Members approve the Bylaws changes indicated in Appendix F.

REVISION OF FOUNDATION ARTICLES OF INCORPORATION AND CHARTER

The Foundation's Articles of Incorporation and Charter, granted by the Commonwealth of Pennsylvania in September 1971, states that the Foundation intended to apply for tax exemption under Section 501 (c) (3) which legal counsel has subsequently concluded is not the appropriate course of action. Based on the advice of legal counsel, papers are filed with the Internal Revenue Service for tax exemption under Section 501 (c) (4) of the Internal Revenue Code.

Section 501 (c) (4) deals with civic leagues and social welfare organizations which are defined as organizations not organized for profit and operated exclusively for the promotion of social welfare.

In order to proceed with the Section 501 (c) (4) filing, it will be necessary to revise the Articles of Incorporation by deleting Items 8 and 9 which make mention of the fact that the Foundation originally planned to file under Section 501 (c) (3).

IRS has granted an extension until November 30, 1974 to the Foundation for completing the filing for tax exemption, which is necessary for the preparation of the Foundation's 1974 Tax Return.

Recommendation

The Board of Directors recommends that the Administrative Members approve the following resolution:

"Resolved, that Items 8 and 9 be stricken from the Articles of Incorporation of Pennsylvania Medical Care Foundation whereupon Item numbered 10 shall be renumbered Item number 8 of said Articles."

ELECTION OF FOUNDATION BOARD MEMBERS

In accordance with ARTICLE XI - ELECTIONS, *Section 1. Board of Directors*, the Foundation's Bylaws require the Foundation's Board of Directors to submit at least one nominee to the Administrative Members for each vacancy of a physician Board Member elected by the Administrative Members. The first term of the following Board Members expires in October 1974:

1. Joseph N. Demko, M.D. (Lackawanna County)
2. Henry H. Fetterman, M.D. (Lehigh County)
3. Matthew Marshall, Jr., M.D. (Allegheny County)
4. William B. McNamee, M.D. (Delaware County)
5. George R. Moffitt, Jr., M.D. (Dauphin County)
6. Raymond J. Saloom, D.O. (Pennsylvania Osteopathic Medical Association)

Each of the above-mentioned Board Members is eligible for election to another term.

The Foundation's Board of Directors submits the following nominees for each of the six (6) Board vacancies for consideration by the Administrative Members:

Vacancy 1 - Joseph N. Demko, M.D.
Vacancy 2 - Henry H. Fetterman, M.D.
Vacancy 3 - Matthew Marshall, Jr., M.D.
Vacancy 4 - William B. McNamee, M.D.
Vacancy 5 - George R. Moffitt, Jr., M.D.
Vacancy 6 - Raymond J. Saloom, D.O.

The Foundation's Bylaws provide for additional nominations to be made from the floor at the time of elections.

Note: Appendices B, C, D, and E are available upon request. Bylaws changes were approved by the Corporation as recommended. Incumbent members of the Board of Directors were re-elected.

Pennsylvania Medical Care Foundation

Board of Directors

*Mr. Robert A. Albright
Vice President, U.S. Steel and Carnegie Pension Fund,
Room 2684, 600 Grant Street,
Pittsburgh, Pennsylvania 15230

J. Reed Babcock, M.D.
421 North Allegheny Street, Bellefonte, Pennsylvania 16823

Leonard Bachman, M.D.
Health Services Director, Office of the Governor,
Commonwealth of Pennsylvania
Harrisburg, Pennsylvania 17120

Howard W. Baker, M.D.
Vice President, Provider Relations,
Philadelphia Blue Cross, 1333 Chestnut Street,
Philadelphia, Pennsylvania 19107

Mr. Warren E. Barnhart
General Personnel Supervisor,
Bell Telephone Company of Pennsylvania, 1 Parkway,
Philadelphia, Pennsylvania 19102

Joseph N. Demko, M.D.
115 West Drinker Street, Dunmore, Pennsylvania 18512

*Robert B. Edmiston, M.D.
3301 Schoolhouse Lane, Harrisburg, Pennsylvania 17109

*Henry H. Fetterman, M.D., *Vice President*
501 North Seventeenth Street,
Allentown, Pennsylvania 18104

*George R. Fisher, III, M.D.
Suite 308, 829 Spruce Street,
Philadelphia, Pennsylvania 19107

Mrs. Frankie M. Jeter
Welfare Rights Organization, 451 Century Building,
Seventh Street at Penn Avenue,
Pittsburgh, Pennsylvania 15222

Sidney O. Krasnoff, M.D.
1351 West Tabor Road, Philadelphia, Pennsylvania 19141

*Mr. Vincent Lechner, *Secretary*
President, American Sterilizer Corporation,
2424 West 23rd Street, Erie, Pennsylvania 16506

*Matthew Marshall, Jr., M.D., *President*
570 Medical Center East, 211 North Whitfield Street,
Pittsburgh, Pennsylvania 15206

Marvin Maser, D.D.S.
1401 De Kalb Street, Norristown, Pennsylvania 19401

William B. McNamee, M.D.
151 Long Lane, Upper Darby, Pennsylvania 19082

George R. Moffitt, Jr., M.D.
92 Tuscarora Street, Harrisburg, Pennsylvania 17104

Joseph J. Namey, D.O.
3750 West 26th Street, Erie, Pennsylvania 16506

Mr. Edward H. Noroian
President, Board of Trustees,
Presbyterian-University Hospital, 230 Lothrop Street,
Pittsburgh, Pennsylvania 15213

William G. Ridgway, M.D.
115 North Ninth Street, Akron, Pennsylvania 17501

William C. Ryan, M.D.
105 West Church Street, Somerset, Pennsylvania 15501

*Raymond J. Saloom, D.O.
301 Prairie Street, Harrisville, Pennsylvania 16038

Robert A. Schein, M.D.
5257 Greenridge Drive, Pittsburgh, Pennsylvania 15236

Sydney E. Sinclair, M.D.
Executive Vice President, Planning and Professional Affairs,
Pennsylvania Blue Shield,
Camp Hill, Pennsylvania 17011

*Mr. Albert W. Speth
Administrator, Lock Haven Hospital,
Lock Haven, Pennsylvania 17745

Robert B. Stuart, M.D.
1565 West 38th Street, Erie, Pennsylvania 16508

Gabriel F. Tucker, Jr., M.D.
Broad and Ontario Streets,
Philadelphia, Pennsylvania 19140

*Member of Executive Committee
September 15, 1974

BYLAWS
PENNSYLVANIA MEDICAL CARE FOUNDATION

ARTICLE I - GENERAL PROVISIONS AND PROPERTY INTERESTS

Section 1. Business to be conducted without profit:

This Corporation shall conduct and carry on its business without profit to itself or its members or any class thereof. No member of this Corporation shall by reason of membership herein be or become entitled at any time to receive any assets, property, income, or earnings from the Corporation, or to profit therefrom in any manner.

Section 2. Use of income:

All of the income, revenue, and earnings of the Corporation, unless otherwise limited, shall be held, used, managed, devoted, expanded, and applied in the discretion and judgment of the Board of Directors, to carry out the objectives and purposes of the Corporation, and without profit, direct or indirect, to any member of the Corporation as such; provided, however, that officers, agents, and representatives of the Corporation who may be elected by the Board of Directors may be paid such reasonable salaries or compensation for work done or services performed for the Corporation as the Board of Directors shall from time to time determine.

Section 3. Distribution of assets on dissolution:

In the event of the dissolution of this Corporation all of its assets and property, if any, after payment and satisfaction of all claims and demands, the Corporation and all liabilities of the Corporation shall be conveyed and transferred to such non-profit organization as the Board of Directors of this Corporation shall determine.

ARTICLE II - MEMBERSHIP

Section 1. Classes of membership:

There shall be two classes of membership in this Corporation, namely, administrative members and participating members.

Section 2. Qualifications of administrative members:

Administrative members shall consist of those persons who are duly qualified and elected delegates to the House of Delegates of the Pennsylvania Medical Society, a non-profit corporation. Whenever any administrative member of this Corporation ceases for any reason to be a delegate to the House of Delegates of the Pennsylvania Medical Society, his administrative membership in this Corporation shall immediately and automatically terminate and cease, although his membership as a participating member, as hereinafter defined, may continue. No fee shall be charged for admission to administrative membership in this Corporation. The acceptance of election as a delegate to the House of Delegates of the Pennsylvania Medical Society by an eligible physician shall be determined to be acceptance of administrative membership in this Corporation and an intention to be bound by the Articles of Incorporation and Bylaws of this Corporation unless the delegate otherwise notifies the Secretary of the Corporation prior to the Annual Meeting.

Section 3. Qualifications of participating members:

Any licensed physician in the Commonwealth of Pennsylvania, who is a member in good standing of the Pennsylvania Medical Society or the Pennsylvania Osteopathic Medical Association, or who is eligible for membership therein shall be eligible to apply for election to participating membership in this Corporation. Admission to participating membership may be granted by whatever procedure is determined by the Board of Directors to any such person so qualified upon his making application therefor in such form as may be prescribed by the Board of Directors. The dues and assessments to be charged, if any, for admission to participating membership [to be imposed upon participating members,] shall be determined by the Board of Directors.

Section 4. Voting rights and privileges of administrative members and participating members:

The election of the physician members to the Board of Directors of the Corporation shall be vested in

the administrative members by a majority vote of those administrative members present and voting. Each administrative member shall be entitled to one (1) vote on all propositions submitted.

Administrative and participating members may submit names for nominees for Board vacancies. Such nominations shall be presented thirty (30) days prior to the annual meeting of the administrative members.

Section 5. Term of membership:

Participating membership in this Corporation shall be for a period as determined by the Board of Directors.

Section 6. Procedure for admission to participating membership:

Any person who desires to become a participating member of this Corporation shall fill out and sign the application blank provided for that purpose by the Corporation. Such application blank shall be in the form or forms prescribed by the Board of Directors. The Board of Directors shall establish an appeal procedure which shall be available to any applicant who has been rejected for participating membership.

Section 7. Nontransferability of membership:

Neither participating membership in this Corporation nor any certificate evidencing the same shall in any manner be transferable.

Section 8. Membership roll:

A written record of the participating membership of this Corporation shall be kept by the Secretary, and said record shall contain the name and address of each participating member, and in any case where any membership has been terminated for any reason whatsoever, entry of such fact together with the date on which said membership was so terminated shall be entered.

ARTICLE III - CERTIFICATES OF MEMBERSHIP

Section 1. Certificates:

Certificates of membership shall be issued to participating members in such form as may be determined by the Board of Directors.

ARTICLE IV - MEETINGS OF MEMBERS

Section 1. Annual meetings:

Annual meetings of the administrative members shall be held at the same time and place as the regular annual meeting of the House of Delegates of the Pennsylvania Medical Society. Notice of all annual meetings is hereby dispensed with.

Section 2. Special meetings:

Special meetings of the administrative members may be requested at any time by (a) one-third (⅓) of the members of the Board of Directors, or (b) one-fifth (⅕) of the administrative members of the Corporation, or (c) two hundred fifty (250) participating members of the Corporation for the transaction of such business as set forth in the request for call. Such requests shall be in writing and delivered to the Secretary of the Corporation, and thereupon the Secretary shall fix the time and place for the session, which shall not be less than forty (40) and not more than ninety (90) days after receipt of the request, and shall call the session by appropriate notice, which shall state the purpose.

Section 3. Quorum:

The presence in person of a majority of administrative members of this Corporation shall constitute a quorum for the transaction of business. The members present at a duly called or held meeting at which a quorum is present may continue to do business until adjournment notwithstanding the withdrawal of enough members to leave less than a quorum.

ARTICLE V - BOARD OF DIRECTORS

Section 1. Composition of Board of Directors:

The Board of Directors of this Corporation shall be composed of at least twenty (20) members, a majori-

ty of whom must be physicians *elected by the administrative members.* [who are participating members of this Corporation, except that the requirement for participation does not apply until certificates for participating membership are issued.]

One (1) physician member shall be elected to the Board of Directors of this Corporation for every one thousand (1,000) members or fraction thereof of the membership of the Pennsylvania Medical Society and one (1) member elected to the Board of Directors for every one thousand (1,000) members or fraction thereof of the membership of the Pennsylvania Osteopathic Medical Association.

The Board of Trustees and Councilors of the Pennsylvania Medical Society shall elect one (1) member to serve on the Board of Directors of this Corporation. [Each divisional governing body shall be represented by at least one (1) of its members on the Board of Directors of this Corporation.]

At least one-fourth (¼) of the members of the Board of Directors of this Corporation shall be composed of public representatives elected by the Board of Directors. In addition, representatives of other organizations may be elected to serve on the Board of Directors as deemed appropriate by the Board of Directors. At least two (2) of the representatives of other organizations may be elected to serve on the Board of Directors as deemed appropriate by the Board of Directors. At least two (2) of the representatives of other organizations should be representatives of the Hospital Association of Pennsylvania.

Section 2. Term of office:

The first Directors designated as such in the Articles of Incorporation of this Corporation shall hold office and exercise all powers granted to the Board of Directors until the physician members of a new Board of Directors are elected by the administrative membership in accordance with these Bylaws. The new Board of Directors so elected may be composed of all, some, or none of the first Directors designated as such in the Articles of Incorporation. One-third (⅓) of the members of the Board of Directors shall be elected for a period of three (3) years, one-third (⅓) for a period of two (2) years, and one-third (⅓) for a period of one (1) year. Yearly thereafter, one-third (⅓) new members shall be elected to the Board of Directors of this Corporation for a period of three (3) years. No Director shall serve more than two (2) consecutive terms. A member elected to serve an unexpired term or an original member of the Board serving less than three (3) years shall not be regarded as having served a term unless he has served more than two (2) years, and for this purpose a year shall be deemed to be the period between annual meetings of the administrative members.

Section 3. Vacancies:

In the event of a vacancy on the Board of Directors, the vacancy may be filled by a majority vote of the Board of Directors until the next annual meeting of the administrative members.

Section 4. Removal from office:

Any Director may be removed from office as such by the affirmative vote of two-thirds (⅔) of the administrative members, at any annual or special meeting of the members. [, on] *A* written notice setting forth the reasons and grounds therefor, *shall be* mailed to such Director at his last known address at least ten (10) days prior to the date of such meetings.

Any Director elected by the Board of Directors of this Corporation may be removed from office as such by the affirmative vote of two-thirds (⅔) of the members of the Board, at any regular or special meeting of the Board. [, on] *A* written notice setting forth the reasons or grounds therefor, *shall be* mailed to such Director at his last known address at least ten (10) days prior to the date of such meetings.

Section 5. Duties of Directors:

The Board of Directors shall be the policy-making body of this Corporation between sessions of the administrative members. Subject to [these Bylaws,] the supervisory control of the House of Delegates of the Pennsylvania Medical Society, as [hereinabove] set forth *in these Bylaws,* the Board of Directors shall control and manage the Corporation's properties; it shall conduct the affairs and business of the Corporation and make such rules and regulations therefor as deemed to be in the best interests of the Corporation; it shall elect and remove all of the officers, agents, and the chief administrative officer of the Corporation; it shall prescribe such powers and duties *of officers, agents, and the chief administrative officer* [from them]

as may not be inconsistent with the law, with the Articles of Incorporation, or with these Bylaws; it shall appoint an Executive Committee and other committees and may delegate to the Executive Committee any of the power and authority of the Directors in the management of the business and affairs of this Corporation, except the power to adopt, amend, or repeal Bylaws; it shall perform such other duties as are authorized by the Articles of Incorporation, these Bylaws, or as prescribed by law governing directors of corporations.

ARTICLE VI - MEETINGS

Section 1. Regular meetings:

Regular meetings of the Board of Directors shall be held at such times and places as may be designated by rule, regulation, or other appropriate action by the Board of Directors. Notice of such meetings shall be given as determined by the Board of Directors by rule, regulation, or other action.

Section 2. Special meetings:

Special meetings of the Board of Directors for any purpose or purposes may be called at any time by the President, or if he is absent or unable to act, or refuses to act, then by the Vice President or by any five (5) Directors.

Written notice of the time and place of special meetings shall be given to all Directors at least twenty-four (24) hours prior to the holding of the meeting. Notice may be given by a personal telephone call, telegram, or mail.

Section 3. Written consents and waivers of notice:

The transactions of any meeting of the Board of Directors, however called and noticed, and wherever held, shall be valid as though had at a meeting duly called after regular call and notice, if a quorum be present and if either before or after the meeting each of the Directors not present signs a written waiver of notice or a consent to holding such meetings, or an approval of the minutes thereof. All such waivers, consents, or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

ARTICLE VII - OFFICERS

Section 1. Officers:

The officers of this Corporation shall be a President, a Vice President, a Secretary, a Treasurer, and such other officers as the Board of Directors may elect. All officers of this Corporation shall be members of the Board of Directors except that the Treasurer need not be a member of the Board. The Assistant Treasurers and Assistant Secretaries may be employees of this Corporation.

Section 2. Election:

The officers of the Corporation shall be chosen annually by the Board of Directors after each annual election, and each shall hold his office until he shall resign, be removed, or otherwise disqualified to serve, or his successor shall be elected and qualified.

To qualify as President of this Corporation, the Director so elected must have served at least one (1) year on the Board of Directors. This requirement shall not apply to either the first or the second President appointed by either the first or the second Board of Directors elected in accordance with these Bylaws.

Section 3. Removal and resignation:

Any officer may be removed by the affirmative vote of two-thirds (⅔) of the Directors in office at the time at any regular or special meeting of the Board.

Any officer may resign at any time by giving written notice to the Board of Directors or to the President, or to the Secretary of the Corporation. Any such resignation shall take effect at the date of the receipt of such notice, or any later time specified therein, and unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

Section 4. Vacancies:

A vacancy in any office because of death, resignation, removal, disqualification, or any other cause,

shall be filled in the manner prescribed in these Bylaws for regular appointments to such office.

Section 5. Term of office:

The term of office for officers shall be one (1) year. An officer may be re-elected to an office and is eligible to serve a maximum of three (3) consecutive one (1) year terms. The term of office limitation does not apply to the Treasurer.

ARTICLE VIII - DUTIES OF OFFICERS

Section 1. President:

The President shall preside at all general and special meetings of the Board of Directors and the administrative membership and shall serve as Chairman of the Board's Executive Committee, and act as the official spokesman for the Corporation. He shall be an Ex Officio member of all standing and special committees of the Board, with vote, and shall have such other powers and duties as may be prescribed by the Board of Directors, and these Bylaws.

Section 2. Vice President:

In the absence or disability of the President, the Vice President shall perform all the duties of the President and, when so acting, shall have all of the powers of and be subject to all the restrictions upon the President. The Vice President shall have such other powers and perform such other duties as may be prescribed for him by the Board of Directors or by these Bylaws.

Section 3. Secretary:

The Secretary shall keep, or cause to be kept, a book of minutes at the principal office of the Corporation, or such other place as the Board of Directors may order, of all meetings of the Board of Directors. He shall also keep and maintain the membership certificate book and the membership roll of the Corporation's membership and records of the termination of membership in the Corporation. The Secretary shall have such other powers and perform such other duties as may be prescribed by the Board of Directors or by these Bylaws.

Section 4. Treasurer:

The Treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the Corporation, including account of its assets, liabilities, receipts, disbursements, gains, and losses. The Treasurer shall have such other powers and perform such other duties as may be prescribed by the Board of Directors or by these Bylaws.

Section 5. Assistant Secretary:

The Assistant Secretary of the Corporation shall exercise such powers and perform such duties as shall be determined, from time to time, by the Board of Directors. In the event of the death, resignation, or inability of the Secretary to act, the President of the Corporation may authorize the Assistant Secretary to exercise all of the powers and duties of the Secretary until the next meeting of the Board of Directors.

Section 6. Assistant Treasurer:

The Assistant Treasurer of the Corporation shall exercise such powers and perform such duties as shall be determined, from time to time, by the Board of Directors. In the event of the death, resignation, or inability of the Treasurer to act, the President of the Corporation may authorize the Assistant Treasurer to exercise all of the powers and duties of the Treasurer until the next meeting of the Board of Directors.

Section 7. Executive Director:

The Executive Director of the Corporation shall be appointed by the Board of Directors on an annual basis and be responsible thereto. He need not be a physician or participating member of the Corporation. The Executive Director shall be the administrative head of the Corporation and shall be responsible for the administration of the Corporation's headquarters and regional offices. He shall, within the budgetary limitations imposed by the Board of Directors, be empowered to: (a) employ such personnel, at such salaries and under such terms and conditions of employment as he shall determine; (b) provide administrative and clerical assistance and arrange the business details and facilities for meetings for the Corporation, Board

of Directors, the officers and the committees, as he deems necessary for the effective operation of the Corporation, the conduct of its meetings; and (c) repair and maintain the real and personal property of the Corporation.

The Executive Director shall attend all meetings of the Board of Directors and he shall be responsible for the preparation of the agenda of these meetings.

The Executive Director shall conduct the correspondence of the Corporation, notify all members of their election to office, and issue - over the proper signature - all notices required by the Bylaws or by action of the Board of Directors.

The Executive Director shall render a report to the Board of Directors at each of its meetings.

The Executive Director shall serve, at all times, to perform such other duties as may be assigned to him by the Board of Directors and he shall be custodian of all books, records, and papers belonging to the Corporation and he shall keep careful and detailed accounts of such funds delivered into his hands in the name of the Corporation, promptly placing these under the supervision of the Treasurer.

In the event of a vacancy in the position of Executive Director, the Board of Directors, or its Executive Committee, shall designate a member of the administrative staff to act as Executive Director until a permanent appointment is made.

ARTICLE IX - EXECUTIVE COMMITTEE AND OTHER COMMITTEES ESTABLISHED BY DIRECTORS

Section 1. Executive Committee:

There is hereby created an Executive Committee to be elected by the Board of Directors. The Executive Committee shall be composed of at least five (5) members and shall be representative of the composition of the Board of Directors. The Executive Committee shall be vested with all of the powers of the Board of Directors, except as otherwise restricted by the Board of Directors, when the Board of Directors is not in session. The Executive Committee shall report all actions taken at the next meeting of the Board of Directors.

Section 2. Standing committees:

[Standing committees of this Corporation shall be a Patient Relations Committee and a Public Advisory Council. Other standing] *Standing* committees *of this Corporation* may be established as deemed appropriate by the Board of Directors.

Section 3. Appointment and term of office of committee members:

The members of the Committees and the chairman of each shall be appointed by the President subject to the approval of the Board of Directors and shall hold office for a period of one (1) year.

Section 4. Composition and duties of committees:

Each standing committee shall have as many members thereon as the Board of Directors may from time to time determine, and shall have such duties and perform such functions as may be required of them by the Board of Directors.

Section 5. Other committees:

The Board of Directors may from time to time create other [standing and special] committees, appoint the members thereof, and invest therein such powers and duties as it may deem desirable.

Section 6. Dispensing with committees, and removal of committee members:

The Board of Directors, by majority vote, may dispense with any or all standing committees, or may remove any member or all of the members from said committees, in their absolute discretion.

ARTICLE X - REGIONAL DIVISIONS

Section 1. Organization

The Board of Directors of this Corporation may provide advice, and assist in the organization of regional

divisions which shall be responsible for the local operation of the Corporation's programs. The Board of Directors of this Corporation may provide advice and assist county medical societies in determining the appropriate county groupings for the purpose of establishing boundaries for regional divisions.

Section 2. Responsibilities:

The regional divisions will report all activities, actions, and recommendations to the Board of Directors of this Corporation. The Board of Directors of this Corporation may advise and assist in the development of rules and regulations governing the organization and operation of regional divisions.

ARTICLE XI - ELECTIONS

Section 1. Board of Directors:

The administrative members of this Corporation shall elect by a majority vote and in accordance with these Bylaws and the Articles of Incorporation, the *majority of* physician members of the Board of Directors of this Corporation[.] *as specified in ARTICLE V - BOARD OF DIRECTORS, Section 1. Composition of Board of Directors.* Such election shall be held at the annual meeting of the House of Delegates of the Pennsylvania Medical Society, which shall be the annual meeting of the administrative members of this Corporation.

The Board of Directors of the Corporation shall submit to the administrative members, thirty (30) days prior to the annual meeting of the administrative members, the names of one (1) or more nominees for each vacancy of a physician member on the Board of Directors. In addition, the Pennsylvania Osteopathic Medical Association shall submit names of nominees for each vacancy of their respective representatives as set forth in Article V - Board of Directors, Section 1, Composition of Board of Directors.

The Board of Directors of the Corporation shall, at its first meeting following the annual election, elect the public representatives and representatives of other organizations.

Participating members may submit names for nominees for all Board vacancies. Such nominations shall be presented to the Corporation's Board of Directors thirty (30) days prior to the annual meeting of the administrative members. Administrative members may make nominations from the floor for all Board vacancies under consideration.

Section 2. Officers:

The Board of Directors of this Corporation, at their first meeting following the annual election of the members to said Board as aforesaid, shall by a simple majority vote and in accordance with these Bylaws, elect the officers and the Executive Committee of this Corporation for the ensuing year.

ARTICLE XII - MISCELLANEOUS

Section 1. Inspection of Corporate records:

The membership roll, the books and records, and the minutes of proceedings of the administrative members and directors, shall be open to inspection at the Corporation's principal office upon the written request of any participating member at any reasonable time for a purpose reasonably related to his interest as such participating member, as determined appropriate by the Board of Directors.

Section 2. Checks, drafts, etc.:

All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness, issued in the name of or payable to the Corporation, shall be signed or endorsed by such person or persons and in such manner as may be determined by the Board of Directors.

Section 3. Annual Report:

The Board of Directors shall furnish to the administrative members within one hundred twenty (120) days after the close of the fiscal or calendar year, an annual report of the Corporation's activities and plans and a report on the financial affairs of the Corporation based on an independent audit of the financial records.

The Board of Directors shall report its activities and actions to the Board of Trustees and Councilors of the Pennsylvania Medical Society between meetings of the administrative members.

Section 4. Contracts, etc. - how executed:

The Board of Directors, except as in these Bylaws otherwise provided, may authorize any officer or officers, agent or agents, to enter into any contract or to execute any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances. Unless so authorized by the Board of Directors, no officer, agent, or employee shall have any power or authority to bind the Corporation by any contract or engagement, or to pledge its credit to render it liable for any purpose or to any amount.

Section 5. Inspection of Bylaws:

The Corporation shall keep in its principal office the original or a copy of the Bylaws, as amended, or otherwise altered, which shall be open for inspection by the administrative and participating members at all reasonable times during office hours.

Section 6. Rules of Order:

Sturgis Rules of Order shall be the parliamentary guide when not in conflict with the Articles of Incorporation or these Bylaws.

Section 7. Rules of Professional Conduct:

The Principles of Medical Ethics of the American Medical Association and such other rules of professional conduct as this Corporation may adopt by majority vote of the Board of Directors, shall govern this Corporation and all administrative and participating members, subject, however, to the reviewing powers vested in the House of Delegates of the Pennsylvania Medical Society as hereinabove set forth.

Section 8. Disciplinary proceedings:

Any administrative or participating member who is guilty of a criminal offense or gross misconduct, either as a physician or as a citizen, or who violates any of the Articles of the Articles of Incorporation of this Corporation or these Bylaws, or any of the provisions of the AMA Principles of Medical Ethics and rules of professional conduct as adopted by this Corporation, or who acts contrary to or in violation of any contracts, agreements, or statements of principle of this Corporation, shall be liable to censure, suspension, or expulsion. The Board of Directors of this Corporation shall determine the procedures for disciplinary action.

Section 9. Appeal proceedings:

The Board of Directors shall establish procedures to provide for a fair and impartial hearing for any administrative or participating member who elects to appeal a disciplinary action of this Corporation related to the AMA Principles of Medical Ethics, the Corporation's rules of professional conduct, a criminal offense, violation of any contracts, agreements, or statements of principle of this Corporation.

Section 10. Fiscal and administrative year:

The fiscal and administrative year of this Corporation shall run from *January 1 to December 31 of the succeeding year commencing on January 1, 1974,* [1 July to 30 June of the succeeding year commencing on 1 July 19,] unless otherwise changed by the Board of Directors.

ARTICLE XIII - AMENDMENTS

Section 1. Powers of Directors:

Subject to Section 2 of this Chapter Bylaws may be adopted, amended, or repealed by a majority vote of the Board of Directors. Any administrative or participating member of the Corporation may propose amendments to the Bylaws for consideration by the Board of Directors.

Section 2. Veto powers of House of Delegates and Board of Trustees and Councilors:

All Bylaws adopted or hereinafter adopted, amended, or repealed by the Board of Directors, shall be submitted to the Board of Trustees of the Pennsylvania Medical Society at the time of such adoption, amendment, or repeal of such Bylaw, and said Bylaw or Bylaws so adopted, amended, or repealed shall govern the affairs of the Corporation unless specifically overruled by a two-thirds (⅔) majority of the members of the Pennsylvania Medical Society's Board of Trustees and Councilors. All Bylaws adopted, amended, or repealed shall, in any event, be submitted to the administrative members of this Corporation at the next annual, interim, or special meeting of said body, for their approval.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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DECEMBER 1974 VOLUME 77, NUMBER 12

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Cover by: Jack Schmidt

medigram

December 1974

COMPREHENSIVE HEALTH PLANNING IN LIMBO Several bills to regulate health care and provide hospital cost containment legislation died when the Legislature adjourned without reaching agreement on what legislation was needed. The State Society's Board of Trustees at its November 13 meeting withdrew its previous support for cost containment legislation because the Senate added undesirable amendments. Governor Milton J. Shapp, however, has said comprehensive health care legislation would be at the top of the administration's list of priorities for 1975, and leaders in the Legislature are prepared to reintroduce legislation on comprehensive health planning early in 1975.

CHILD ABUSE BILL PASSED The "Child Protection Services Act" has been approved by the Legislature and establishes a statewide computerized registry on child batterings, requiring authorities to report suspected cases of abuse. All medical, law enforcement, and social service officials are required to report child abuse to the registry, as are any witnesses to a child battering. The registry will have a 24-hour "hotline" for anyone to report suspected cases.

PAMPAC REPORTS TO BOARD R. William Alexander, M.D., of Reading, chairman of the Board of Directors of the Pennsylvania Medical Political Action Committee (PaMPAC), reported to the Board of Trustees in November that the committee had contributed $81,000 over a two-year period to support ninety-nine candidates in the general election. Of these, 81 percent were elected or reelected. Candidates of both major parties received support. In addition the American Medical Political Action Committee made contributions over a two-year period of nearly $1 million to 245 candidates for Congress, including a number of Pennsylvanians. Dr. Alexander outlined PaMPAC's plans for conducting meetings in the various councilor districts, and asked for support for its sustaining membership campaign. Sustaining members of PaMPAC contribute $100 a year. Regular members contribute $35.

SOCIETY SCHEDULES MANAGEMENT SEMINARS The State Society's Council on Education and Science has scheduled two practice management seminars for 1975. The first, designed for residents, will be held March 4 and 5 at the Host Inn, Harrisburg, Konomikes Associates will conduct this course. On May 2 and 3, Leif Beck Associates will present a seminar, "Principles of Medical Practice Management," at the Penn Harris Motor Inn, Camp Hill. For further information contact the Council on Education and Science, 20 Erford Road, Lemoyne, Pa. 17043.

PHYSICIANS' ASSISTANTS AUTHORIZED Legislation giving the state's osteopathic and medical licensing boards authority to regulate physicians' assistants was passed by the Legislature in the final days of the session which ended November 30.

The essence of the legislation is an addition to the medical practice act which says: "Nothing in this act shall be construed to prohibit services and acts rendered by a physician's assistant, or other allied medical person, if such services and acts are rendered under the direction or control of a licensed physician." This language recognizes physicians' assistants as an entity under the Act and would give the State Board of Medical Education and Licensure permission to write rules and regulations covering them. The State Society supported regulation of physicians' assistants by the State Board of Medical Education and Licensure.

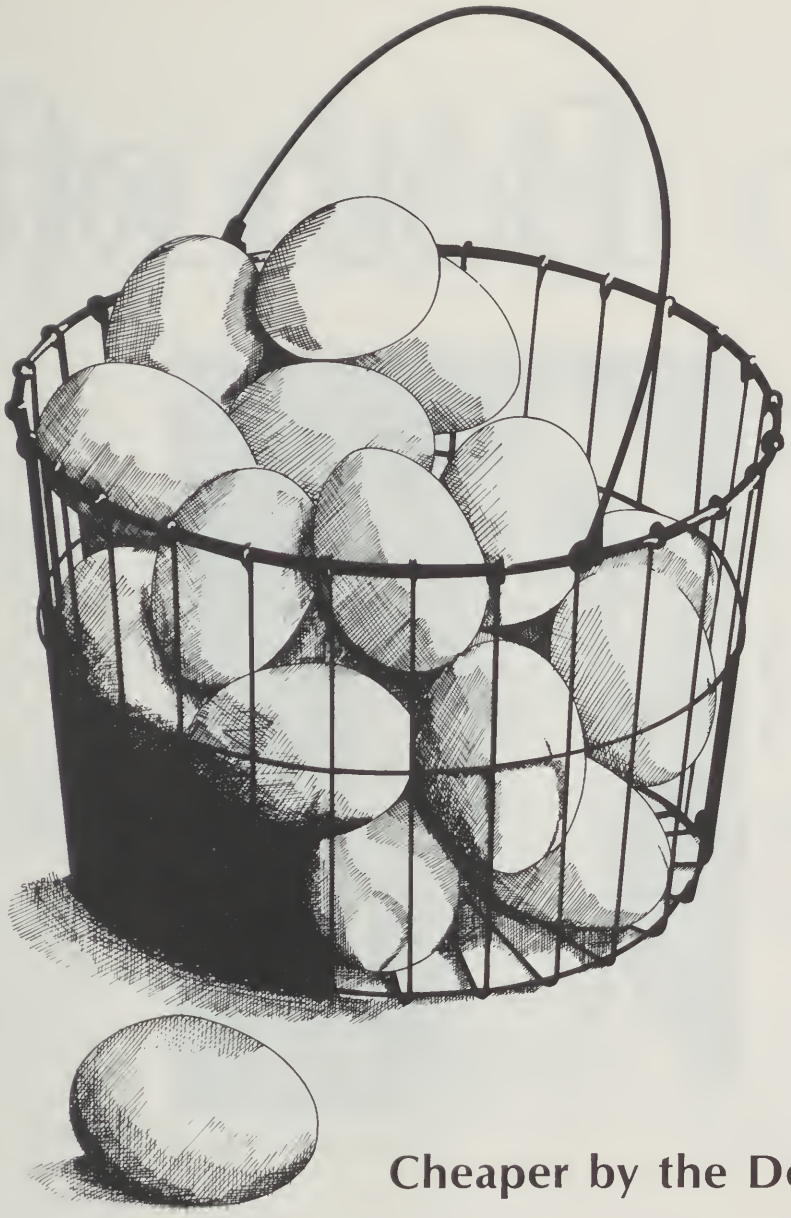
COUNCIL TO STUDY MANPOWER The Board of Trustees in November asked the Council on Education and Science to prepare statistics on physicians' education and the production of physicians in Pennsylvania during the past decade and on the use of and need for physicians' assistants. The council will report its findings to the Board in January.

JOIN COOPERATIVE NOW--PRIZE MAY BE YOURS The Pennsylvania Medical Cooperative, in the last phase of its charter membership drive, has scheduled a drawing as an added incentive to reach its goal of 2,000 members by January 31, 1975, the final day to become a charter member. All charter members will be eligible to win a grand prize of a trip for two with all expenses paid to the British Isles and Holland, courtesy of the Lehigh County Medical Society and its travel agency, Intrav. Additional prizes of office supplies will be awarded. Details are on page 11 of this issue, and a clip-out coupon to join appears on page 10.

STATE BOARD REORGANIZES The State Board of Medical Education and Licensure elected William J. Kelly, M.D., vice president of the State Society, as chairman, and Richard C. Lyons, M.D., of Erie, as vice chairman at its November 7-8 meeting. Dorothy L. Bupp became secretary of the state board December 1, replacing Alva L. Cockley, who has retired.

PMS MEMBERS ACTIVE AT AMA SESSION Three Society members served on reference committees at the December session of the AMA House of Delegates: Paul S. Friedman, M.D., of Philadelphia; Matthew Marshall, Jr., M.D., of Pittsburgh; and William B. West, M.D., of Huntingdon. William Y. Rial, M.D., Swarthmore, served as vice speaker. Dues statements of the State Society have not been mailed pending the decision of the AMA House regarding a dues increase for 1975.

BIENNIAL PHYSICIAN REGISTRATION FORMS MAILED All physicians licensed to practice in Pennsylvania should have received by now their biennial registration forms. The registration and fee must be returned by December 31. If you have not received your form, contact the State Board of Medical Education and Licensure immediately. The Board may not have your correct address. The Board's address is 279 Boas Street, Harrisburg, Pa. 17102.



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A 30 to 50 per cent saving on the cost of expendable office supplies is a mighty appealing prospect these days. And that is exactly what you can look for when you join the Pennsylvania Medical Cooperative—the mass-buying organization being formed to serve physicians exclusively.

The Cooperative, which will effect its savings by purchasing in large volume directly from the manufacturer and reselling to the physician at cost, will limit itself to expendable supplies in the initial phase of its operation only. Later when it expands its inventory to include more costly items such as surgical supplies and office equipment, the potential for savings will be even greater.

Membership in the Cooperative will be open to Pennsylvania Medical Society members only. The only cost is a nominal $100 once-and-done lifetime membership fee, all or a substantial part of which will be returned if you should decide to withdraw. In all probability you will save more than the amount of the membership fee in your first-year purchases alone.

However, dollar savings are not the only benefit. The Cooperative's system of blanket contracts and automatic shipments will do much to simplify your purchasing procedures and reduce the burden of inventory control.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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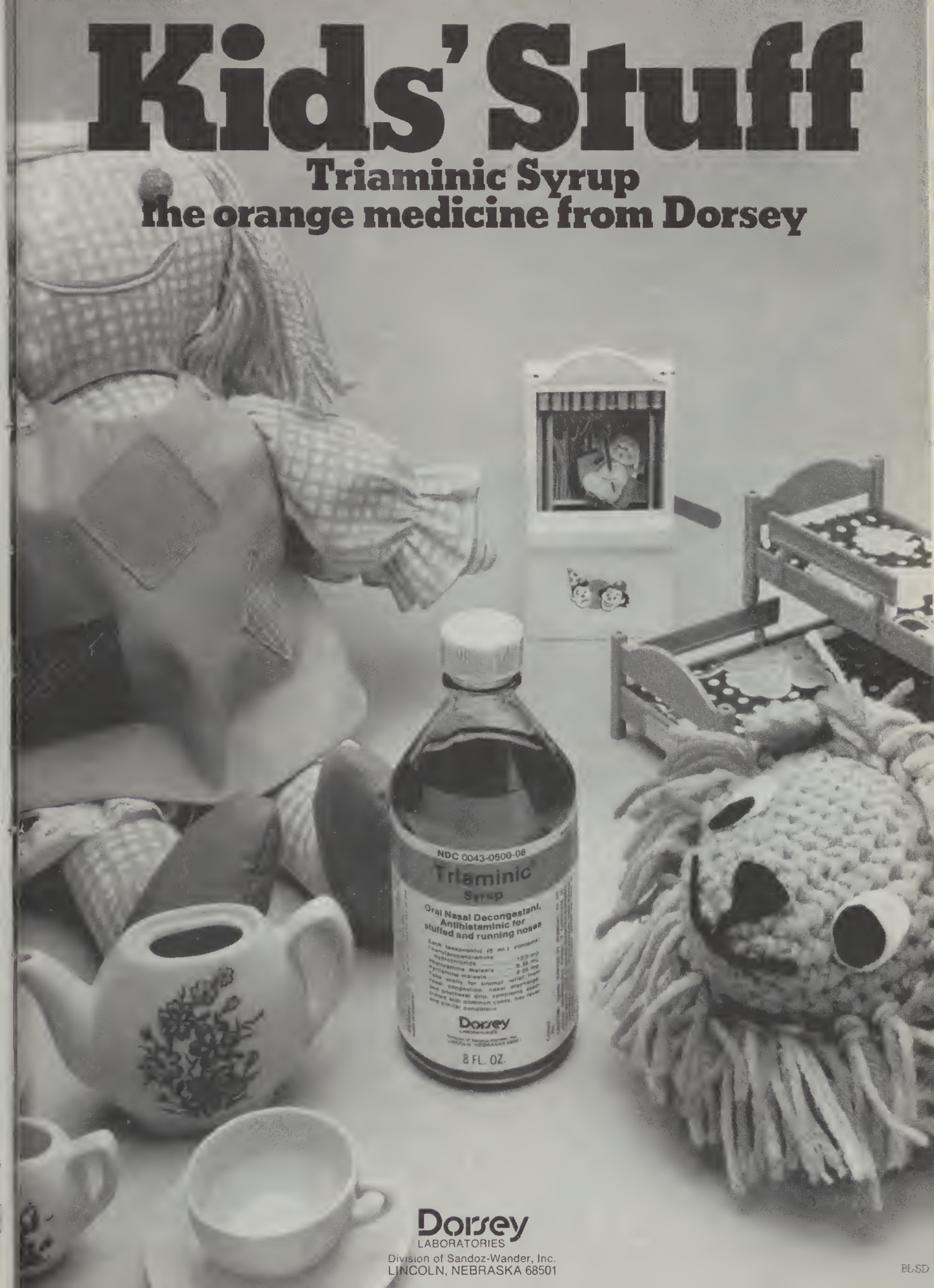

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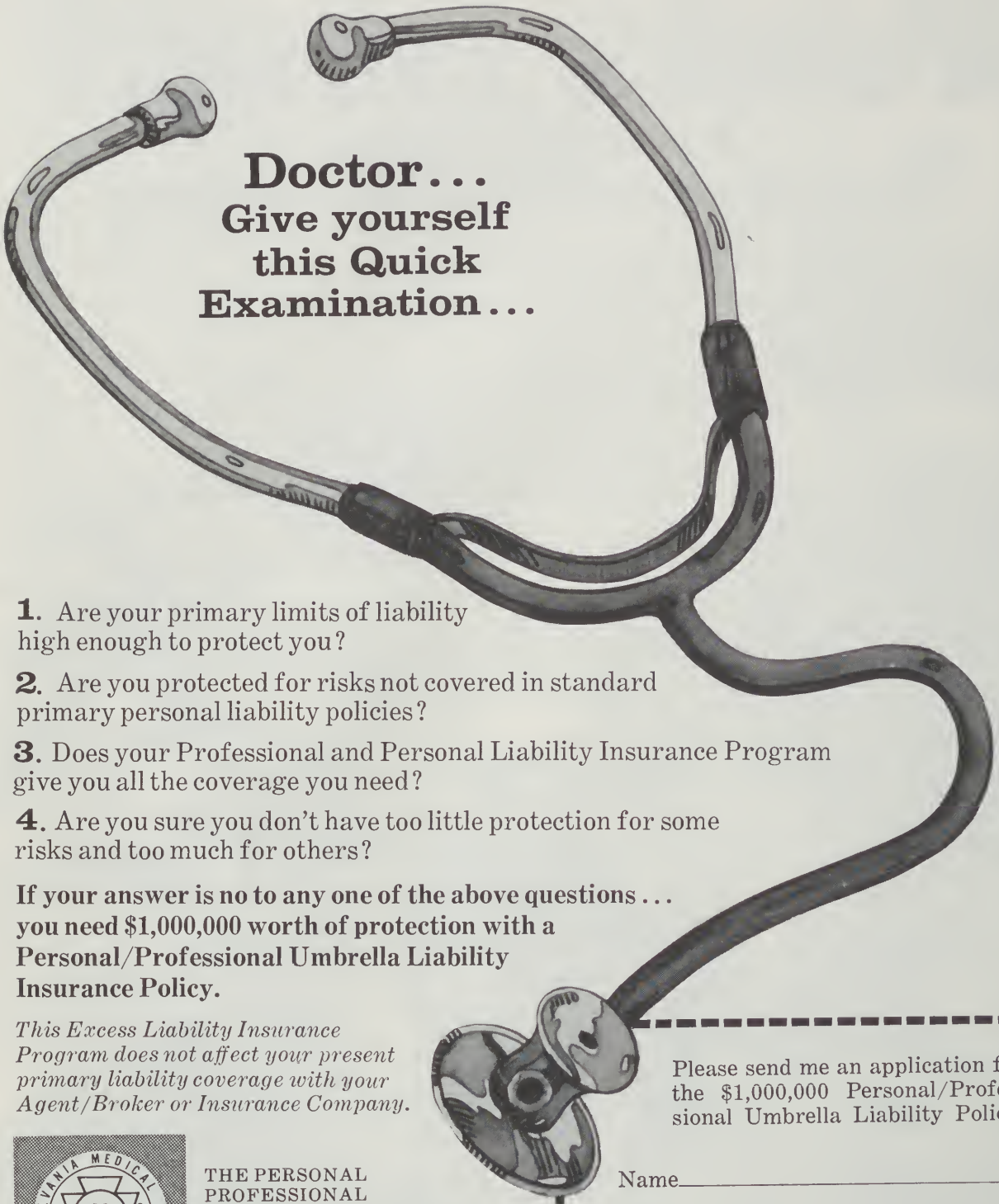

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Education requirement high on 1975 priority list

The final six months to qualify under the State Society's continuing education membership requirement is almost here. June 1975 is the last month in which courses can be taken to qualify for the initial requirement to maintain PMS membership.

Critical are the sixty hours of Category One. To help members with Category One, the Commission on Accreditation is publishing in PENNSYLVANIA MEDICINE two supplements each year which list all continuing education courses in Pennsylvania. The first ran in September 1974. The second will appear in the January 1975 issue. These supplements can be detached from the magazine for easy reference. The August 1974 supplement to JAMA lists Category one courses for the United States and is helpful in planning convention trips.

Members with enough hours during the 1972-73-74 period to qualify for the 1974 award should fill in their applications and send them to the AMA now. Do not send them to the State Society.

About 2,400 PMS members have qualified for the 1973 and 1974 AMA Physician's Recognition Awards. They are now on cycle and must continue every three years to qualify.

However, the vast majority of members are expected to qualify for the 1975 award. By June 30 they must have accumulated their 150 hours. Members who fail to qualify at that time are liable to suspension.

In Pittsburgh this October, the House of Delegates extended the continuing education requirement to include associate members as well as active and senior active dues-paying members. Associate members are doctors 70 years of age and over. Associates who are in active practice and seeing patients will have three years in which to acquire the necessary 150 hours.

DURING the Annual Session of the House of Delegates, the Woman's Auxiliary of the Pennsylvania Medical Society celebrated its Fiftieth Anniversary. In the photo at the top (left to right) are Mrs. Howard Liljestrand, president of the Woman's Auxiliary of the AMA, talking with state auxiliary officers Mrs. Frederick R. Gilmore, president for 1973-74; Mrs. Raymond C. Grandon, president for 1974-75; and Mrs. Richard T. Smith, 1974-75 president elect. The photo underneath shows former presidents and honary members gathered to celebrate the anniversary. At the left, Robert Sanford, M.D., immediate past president of the State Society, presents a thousand dollar check to the incoming auxiliary president, Mrs. Raymond C. Grandon, for the Auxiliary's Health Careers Financial Aid Fund.

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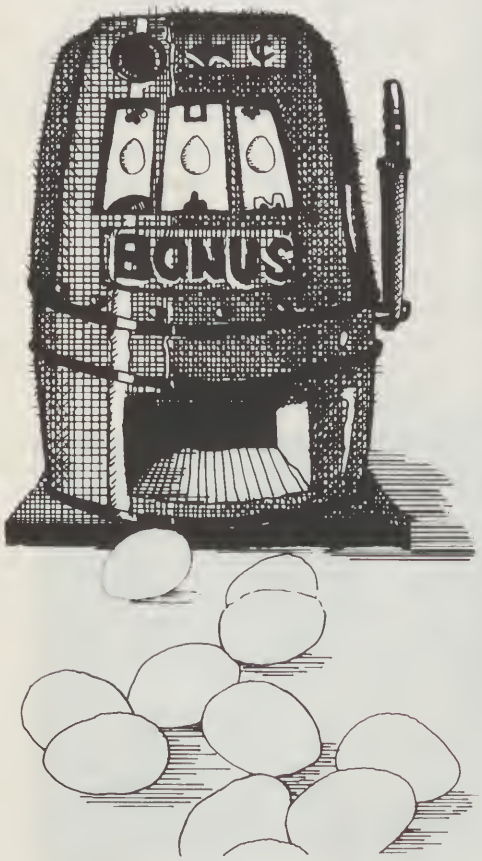

Pennsylvania physicians are responding enthusiastically to the proposed formation of a Pennsylvania Medical Cooperative. They feel the Cooperative's cheaper-by-the-dozen approach to the purchase of medical supplies makes a lot of sense. They also appreciate the fact that they are not being asked to take any financial risk whatever in availing themselves of the Cooperative's benefits.

The idea behind the Pennsylvania Medical Cooperative is a very simple and practical one—and one that is especially appealing in these days of rapidly rising costs. What it means is that instead of purchasing supplies in small quantities, individually, the State's physicians will be banding together to make their purchases on a mass basis, in large volume, at significant savings.

Membership in the Pennsylvania Medical Cooperative will be open to Pennsylvania Medical Society members only, through the once-and-done purchase of a modest $100 lifetime share. If the proposed Cooperative should not materialize, the $100 membership fee will be returned in full.

And even after the Cooperative is in operation, if you should wish to withdraw, all or a substantial part of the membership fee will be returned.

At the outset the Pennsylvania Medical Cooperative will limit itself to the purchase and sale of expendable supplies. By purchasing such supplies in large quantities directly from the manufacturer and reselling them at cost, it is expected that the Cooperative will be able to offer its physician members savings of 30 to 50 percent. Later, when the Cooperative expands into the field of surgical supplies, office equipment and so on, the potential for savings will be even greater.

The Pennsylvania Medical Cooperative has much to recommend it: an opportunity for substantial savings without any risk whatever, and a chance to simplify your purchasing procedures and take a giant stride toward inventory control. For further information, please write or call.

Please enroll me as a charter member of the Pennsylvania Medical Cooperative. Bill me in the amount of $100 to cover the membership requirement. It is my understanding that this is a one-time subscription entitling me to a vote in the affairs of the Cooperative plus giving me the right to purchase all medical supplies offered by the Cooperative.

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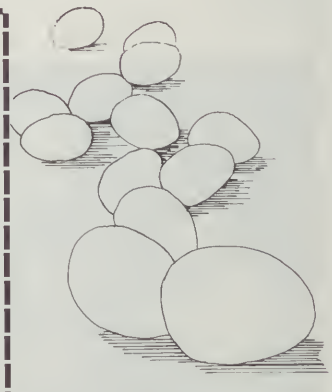
ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER: _____



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Cooperative membership fee to double after January 31

The Society's Council on Professional Relations and Services has established, with the approval of the Board of Trustees, a $200 membership fee for the Pennsylvania Medical Cooperative when the charter membership period closes January 31, 1975. Charter membership, a one-time fee, is $100 until that date.

The council was charged by the House of Delegates to continue its drive to reach a goal of 2,000 paid members before becoming operational but to continue preliminary preparations for the operational phase during the membership campaign. Announcement of future plans came from Ulysses S. Watson, M.D., council chairman.

As an added inducement to encourage charter members, the council at its November 9 meeting voted to hold a drawing, with those eligible to include all charter members, featuring as its main prize a two-week all expense paid tour for two to the British Isles and the Netherlands. Additional prizes of free supplies from the cooperative when it becomes operational are as follows: one worth $500; two prizes of $250 in supplies; three prizes worth $100 each; and ten prizes of medical supplies worth $50. The dollar amounts will be based on cooperative prices, not on current retail prices, thus enhancing their value. The main prize is being offered with the compliments of the Lehigh Valley Medical Society and its travel agency, Intrav.

Additional letters of invitation to join the cooperative are being mailed to Pennsylvania Medical Society members in the event they have not yet been introduced to the concept of mass purchasing to permit members to make substantial savings in the purchase of office business and medical supplies.

When it becomes operational, the cooperative will purchase supplies in large quantities at wholesale prices and resell to members at cost. Initially products offered will include disposable items, most of which have jumped dramatically in price during the current inflationary spiral. Later, the cooperative will offer office and surgical equipment as well.

The cooperative concept is not new in America, but it is new for medical societies. The Pennsylvania Medical Society is the first in the nation to offer this benefit which is limited to Society members.

National blood commission endorsed by HEW officer

Establishment of an American Blood Commission has been endorsed by Caspar W. Weinberger, secretary of the Department of Health, Education, and Welfare, as a result of 80 percent favorable comments received to a suggested plan published in the *Federal Register* in March 1974.

HEW will cooperate with the private sector in efforts to implement a national blood policy and has agreed to sponsor an inaugural convention late this winter. An ad hoc committee will be formed to draft a charter and to establish parameters for coordinating and improving blood service activities.

Local and state participants will include representatives of such organizations as the American Red Cross, the Council of Community Blood Centers, the American Association of Blood Banks, the American Medical Association, the American Hospital Association, the American Society of Clinical Pathologists, and the College of American Pathologists. In addition to blood banking and hospital and medical professionals, third-party payers and consumers will be represented.

Major aims include an all-volunteer blood donor service to reduce the incidence of hepatitis in transfusions, resource sharing methods to prevent waste of the scarce blood supply, and creation of a national distribution system to assure access to recipients regardless of location or economic status.

AS PART of his orientation visit to Society headquarters, Edward N. Moser, M.D. (left), Williamsport, secretary of the Lycoming County Medical Society, reviews the annual report of the Educational and Scientific Trust of the State Society with Alex H. Stewart, executive director of the trust.

Quack cancer "cures" under health department attack

The Pennsylvania Department of Health has mounted a campaign to warn the public against so-called cures for cancer, with such ingredients as broccoli, apricot pits, and coconut oil.

Jack B. Ogun, chief of the state health department's drug, device, and cosmetic compliance section said, "People may easily become the prey of a quack who will first build up their egos by applauding their wisdom in rejecting conventional treatment and then play on their fear and lack of information by telling them that their form of cancer can be cured easily, usually by some 'secret method' which the 'medical establishment' is trying to suppress."

The health department section deals with fraudulent medical preparations which are alleged to cure and are almost always overpriced, usually worthless, and sometimes even hazardous.

Health department spokesmen identified the most serious dangers as being the time wasted before receipt of effective medical treatment and the fact that routinely tranquilizers, antidepressants, and painkillers are dispensed which lull the patient into a false sense of improvement. The price of this false hope costs time, money, and often the patient's life.

Dr. Edmiston appointed

Newly appointed executive vice president designate of professional affairs for Pennsylvania Blue Shield is Robert B. Edmiston, M.D., Harrisburg, who will succeed Sydney E. Sinclair, M.D., when he retires in March.

DR. EDMISTON

Dr. Edmiston is on the medical staff of Polyclinic Hospital. He is a clinical lecturer at Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center, Hershey, and a senior clinical instructor at Hahnemann Medical College, Philadelphia.

He is treasurer of the Area IX Professional Standards Review Organization and a member of the board of directors of the Pennsylvania Medical Care Foundation. Dr. Edmiston is a diplomate of the American Board of Family Practice.

Dr. Muller directs state emergency care

H. Arnold Muller, M.D., has accepted an appointment as medical director of the division of emergency health services for the Pennsylvania Department of Health and as director of emergency care services at the Milton S. Hershey Medical Center of Pennsylvania State University.

In making the appointment, Governor Milton J. Shapp has given Dr. Muller the responsibility for developing the first statewide comprehensive medical services system.

Dr. Muller is assistant professor of medicine at the Pennsylvania State University College of Medicine and will continue as director of the emergency care unit and of the emergency medicine residency training program at Hershey. He is a member of the board of trustees of the Pennsylvania Chapter of the American College of Emergency Physicians and regional director of the University Association for Emergency Medical Services.

Cancer group elects officers

New officers were elected at the annual meeting of the Pennsylvania Cancer Coordinating Committee recently. Robert C. Eyerly, M.D., of the Geisinger Medical Center, Danville, was elected chairman and Hugh R. Gilmore, Jr., M.D., of the Pennsylvania Department of Health was elected secretary.

The coordinating committee is composed of representatives of the Philadelphia divisions of the American Cancer Society, the Pennsylvania Medical Society, the Pennsylvania Dental Association, the Pennsylvania Department of Health, the Pennsylvania Osteopathic Medical Association, the Wainwright Tumor Clinic Association, the Pennsylvania Veterinary Medical Association, the Western Pennsylvania Regional Medical Program, and the Pennsylvania Liaison Fellows of the American College of Surgeons.

Medicare patient costs to rise in 1975

Medicare patient costs are scheduled for increase beginning January 1, 1975. The Department of Health, Education, and Welfare attributes the rise to increasing hospital costs which are subject to annual review and which result in annual medicare rate adjustment.

Medicare hospital deductible Part A will rise from $84 to $92. Coinsurance amounts will rise proportionately. After sixty days, the charge will be $23 per day or one-quarter of the deductible (up from $21). The posthospital nursing facility charge from the twenty-first through the one hundredth day will rise to $11.50 or one-eighth of the deductible (up from $10.50). If lifetime reserve days have been exhausted, the extra sixty hospital days a beneficiary can use when he needs more than ninety days of hospital care in the same benefit period will rise to $46 or one-half of the deductible (up from $42).

The new rates apply to benefit periods beginning in 1975, not to hospitalizations carried over from 1974.

Ophthalmology department history published

A one hundred year history of the department of ophthalmology of the University of Pennsylvania School of Medicine, Scheie Eye Institute, was printed in the October issue of *Transactions and Studies of the College of Physicians of Philadelphia*.

The account, written by Daniel M. Albert, M.D., associate professor of ophthalmology and chief of the eye pathology laboratory at Yale University School of Medicine, gives a comprehensive review of visual science and eye disease as far back as Benjamin Franklin, who developed the bifocal lens in 1785. The history of ophthalmology at the University of Pennsylvania from its founding in 1874 describes the lives of key physicians, their discoveries of new instruments, techniques of treatment, and the progress in eye operations.

Reprints of the article may be obtained by writing Daniel M. Albert, M.D., professor of ophthalmology, Yale University School of Medicine, 333 Cedar St., New Haven, Conn. 06510.

Dr. Rowland AAFP VP

George A. Rowland, M.D., Millville, was elected vice president of the American Academy of Family Physicians (AAFP) at the group's recently held Congress of Delegates. He has been a member of the board of directors since 1972.

Dr. Rowland is a diplomate of the American Board of Family Practice. Prior to the organization's name change, he served the American Academy of General Practice as a member of the board of directors and chaired its Commission on Education.

DR. ROWLAND

He has served on many committees and commissions of the Pennsylvania Medical Society (PMS), including the Executive Committee and the Finance Committee, which he has chaired for the past several years. He is presently a PMS delegate to the American Medical Association and is serving as Trustee and Councilor for the Fourth District, a position which he has held since 1966.

The AAFP is the nation's second largest medical group, with a membership exceeding 36,000 members.

AMA exposes fraud

The State Society took immediate action to warn physicians against deceptive and misleading solicitation from the Mayo Research and Publication Company for an "International Medical Directory of Physicians."

The Society has notified Pennsylvania consumer protection authorities, and the American Medical Association has obtained a fraud order from U.S. postal authorities.

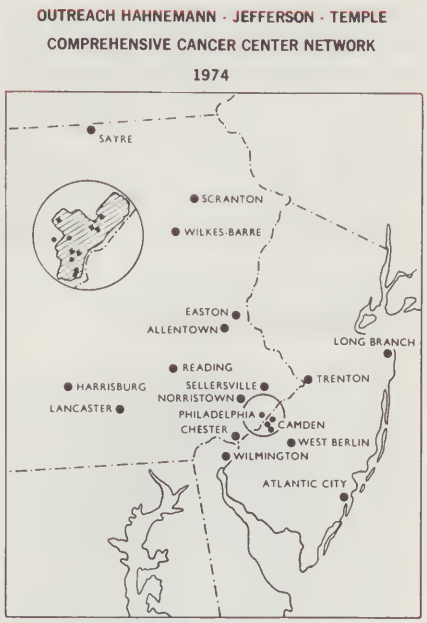
The invoice appears to be a bill for a forthcoming printed directory; but, in fact, your $185 check constitutes an acceptance of an offer to publish your name in the proposed directory.

The directory is not authorized by AMA or PMS and has no connection with the Mayo Clinic. Actually, the firm is located in Hong Kong, and the invoices were mailed through a California postal service. All mail addressed to the firm after November 1, 1974, will be returned to the sender. However, prudence would indicate the advisability of stopping payment on any checks mailed.

Comprehensive cancer center established in Philadelphia

A Comprehensive Cancer Center designed to serve Northeast Pennsylvania, Delaware, and Southern New Jersey has been formed by Hahnemann Medical College and Hospital, Jefferson Medical College of Thomas Jefferson University, and Temple University School of Medicine.

"The banding together of three long-established and respected medical colleges and their affiliates to support the cause of cancer research, treatment, and education is a historic event," said Frank J. Rauscher, head of the National Cancer Institute which supports the



cancer programs of the three medical centers.

An executive board will be made up of the presidents of the three participating institutions (among whom the chairmanship will rotate): Wharton Shober (Hahnemann); Peter A. Herbut, M.D., (Jefferson); and Marvin Wachman, M.D., (Temple). Also serving on the board will be Robert H. Holmes, M.D., senior vice president for medical affairs at Hahnemann; William Kellow, M.D., dean and vice president of Jefferson Medical College; and Roger W. Sevy, Ph.D., M.D., dean, Temple University School of Medicine.

Dr. Crane recipient of W.W. Gerhard medal

A. Reynolds Crane, M.D., president of the Pennsylvania Medical Society, received the William Wood Gerhard Medal of the Philadelphia Pathological Society for distinguished service to pathology in research, teaching, and service on November 14, 1974.

The medal is given annually in memory of W. W. Gerhard, M.D., who was educated at Dickinson and the University of Pennsylvania, where he received his M.D. degree in 1832. He is known for differentiating typhus from typhoid fever before the era of microbiology through studies, done at Pennsylvania Hospital and Philadelphia General Hospital, based upon epidemics of fever about 1834. Then in 1836 Dr. Gerhard furthered the study of disease through carefully recorded scientific observations and the correlation of pathological lesions with clinical signs and symptoms.

Dr. Crane is professor of pathology at the University of Pennsylvania School of Medicine and consultant in pathology at Pennsylvania Hospital. He served the Society as trustee and councilor of the First District from 1963-1972, then as vice president and president elect of the Society prior to his assumption of the Society presidency. He is a founding fellow of the College of American Pathologists.

JCAH establishes accreditation schedule

The Joint Commission on Accreditation of Hospitals' board of commissioners has established a time schedule for accredited hospitals regarding the implementation of retrospective patient care evaluation or outcome audit.

John D. Porterfield III, M.D., JCAH director, reported the deadlines in the September issue of the *Hospital Medical Staff* published by the American Hospital Association. After July 1, 1975, at least two completed outcome audits and two in-process audits per major service will be required. After July 1, 1976, one outcome audit per month per major service must be demonstrated. Major services are defined as medicine and surgery, usually obstetrics and gynecology, and often pediatrics, depending upon the facilities of the particular hospital.

The classification of retrospective outcome audits has been established as a quality control measure to counterbalance the cost control utilization review audits. It is in addition to previously implemented audits controlling clinical privileges, continuing education requirements, utilization review, and concurrent quality control measures.

HEW issues gonorrhea treatment schedules

Physicians are cautioned to use no less than the recommended dosages of antibiotics.

Uncomplicated Gonococcal Infections in Men and Women
Drug Regimen of Choice:

Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, together with one gram of probenecid, by mouth, just before the injections.

Alternative Regimens:

A. Patients in whom oral therapy is preferred: Ampicillin, 3.5 gm, by mouth, together with one gram probenecid by mouth, administered at the same time. There is evidence that this regimen may be slightly less effective than the recommended APPG regimen.

B. Patients who are allergic to the penicillins (penicillin G, ampicillin) or probenecid*:

1. Tetracycline hydrochloride, 1.5 gm initially by mouth, followed by 0.5 gm by mouth four times per day for 4 days (total dosage, 9.5 gm). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as single-dose therapy.
2. Spectinomycin hydrochloride, 2.0 gm intramuscularly, in one injection.

Treatment of Sexual Partners:

Men and women with known recent exposure to gonorrhea should receive the same treatment as individuals known to have gonorrhea. Male sex partners of persons with gonococcal infection must be examined and treated because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men.

Followup:

Followup urethral and other appropriate cultures should be obtained from men, and cervical, anal and other appropriate cultures should be obtained from women, 7 to 14 days after completion of treatment.

Treatment Failures:

Most recurrent infection after treatment with the recommended schedules is due to reinfection. True treatment failure after therapy with penicillin, ampicillin or tetracycline should be treated with 2.0 gm of spectinomycin intramuscularly.

Postgonococcal Urethritis:

Tetracycline, 0.5 gm, four times daily by mouth, for at least 7 days.

Pharyngeal Infection:

Pharyngeal gonococcal infections may be more difficult to treat than anogenital gonorrhea. Post-treatment cultures are essential followup for pharyngeal infection. The schedules of ampicillin and spectinomycin recommended for anogenital gonorrhea are ineffective in pharyngeal gonorrhea. Patients with pharyngeal gonorrhea whose infection is not eradicated after treatment with 4.8 million units of APPG plus one gram of probenecid, may be treated with 9.5 gm of tetracycline in the dosage schedule outlined above (Alternative Regimens).

Syphilis:

All patients with gonorrhea should have a serologic test for syphilis at the time of diagnosis. Seronegative patients without clinical signs of syphilis, who are receiving the recommended parenteral penicillin schedule, need not have followup serologic tests for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a followup serologic test for syphilis after 3 months to detect untreated syphilis.

Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Not Recommended:

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have *NO* place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

Treatment of Uncomplicated Gonorrhea in Pregnant Patients

A. For women who are not allergic to penicillin: Use the regimens of aqueous procaine penicillin G plus probenecid, or use ampicillin plus probenecid, as defined above.

B. Pregnant patients who are allergic to penicillins (there are several possible alternative regimens, each of which has potential disadvantages):

1. Erythromycin, 1.5 gm orally, followed by 0.5 gm four times a day for 4 days, for a total of 9.5 gm. This regimen is safe for mother and fetus, but efficacy has not been established. Erythromycin estolate should not be used in patients with underlying liver disease.
2. Cefazolin, 2 gm intramuscularly, with 1.0 gm of probenecid. Because of the possibility of cross-allergenicity between penicillins and cephalosporins, this regimen should not be used in a patient with a history of penicillin anaphylaxis.
3. Spectinomycin, 2 gm intramuscularly. This is an effective dose, but safety for the fetus has not been established.

Contraindicated:

Tetracycline should not be used for uncomplicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

Acute Salpingitis (Pelvic Inflammatory Disease)

The diagnosis of acute salpingitis should be considered in women with acute lower abdominal pain and adnexal tenderness on pelvic examination. Since there are no completely reliable clinical criteria on which to distinguish gonococcal from nongonococcal salpingitis, endocervical cultures for *N. gonorrhoeae* are essential in such patients. Therapy, however, should be initiated immediately, without waiting for the results of the cultures.

A. **Hospitalization:** Hospitalization should be strongly considered for women with suspected salpingitis in these situations:

1. Uncertain diagnosis, where surgical emergencies must be excluded.
2. Suspicion of pelvic abscess.
3. Pregnant patients with salpingitis.
4. Inability of the patient to follow an outpatient regimen of oral medication, especially because of nausea and vomiting.
5. Failure to respond to outpatient therapy.

B. **Antimicrobial Agents:** Controlled studies of the treatment of acute salpingitis are not available. Initial management must

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* *Allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction.*

AT LEAST be adequate for gonococcal salpingitis. These regimens are known to be adequate for the treatment of gonococcal salpingitis:

1. Outpatients:
   a. 1.5 gm tetracycline hydrochloride, given as a single oral loading dose, followed by 500 mg, taken orally, four times daily for 10 days.
   b. Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, **OR** 3.5 gm of oral ampicillin. One gram of oral probenecid is given along with either penicillin or ampicillin, and both are followed by 500 mg of ampicillin, taken orally, four times daily for 10 days.

2. Hospitalized patients:
   a. Aqueous crystalline penicillin G, 20 million units, given intravenously each day until clear-cut improvement occurs, followed by 500 mg of ampicillin taken orally four times daily, to complete 10 days of therapy. The need for additional or alternative antibiotics for the treatment of nongonococcal salpingitis requires further study. Since it is impossible to distinguish gonococcal from nongonococcal salpingitis clinically, many physicians also use an aminoglycoside in addition to penicillin and/or antibiotics which are effective against **Bacteroides fragilis** as initial therapy.
   b. Tetracycline hydrochloride, 500 mg, given intravenously four times daily until improvement occurs, followed by 500 mg taken orally four times daily, to complete 10 days of therapy. This regimen should not be used for pregnant women or for patients with renal failure.

3. Failure to improve on the recommended regimens does not necessarily indicate the need for stepwise additional antibiotics, but requires reassessment of the possibility of other diagnoses and of the specific microbial etiology.

C. The effect of the removal of an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis requires further study.

D. **Adequate treatment of women with acute gonococcal salpingitis must include examination and appropriate treatment of their male sex partners because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men. Failure to treat male sex partners is a major cause of recurrent gonococcal salpingitis.**

E. Followup of patients with acute salpingitis is essential. All patients should receive repeat pelvic examinations and cultures for *N. gonorrhoeae* after treatment.

Disseminated Gonococcal Infection

A. Equally effective treatment schedules in the arthritis-dermatitis syndrome include:

1. Aqueous crystalline penicillin G, 10 million units intravenously per day for 3 days, or until there is significant clinical improvement. This may be followed with ampicillin, 500 mg four times a day orally, to complete 7 days of antibiotic treatment.
2. Ampicillin, 3.5 gm orally, plus probenecid, 1.0 gm, followed by ampicillin, 500 mg four times a day orally, for at least 7 days.

B. In penicillin and/or probenecid allergic patients:

1. Tetracycline, 1.5 gm orally, followed by 500 mg four times a day orally, for at least 7 days. Tetracycline should not be used for complicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

2. Erythromycin, 0.5 gm intravenously every 6 hours, for at least 3 days.

C. Additional measures:

1. Hospitalization is indicated in patients who are unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.

2. Immobilization of the affected joint(s) appears helpful. Repeated aspirations and saline irrigations appear beneficial, but controlled studies of these procedures have not been performed. Open drainage of joints other than the hip is now generally discouraged in patients with gonococcal arthritis.

3. Intra-articular administration of penicillin is unnecessary, since penicillin levels in the synovial fluid of inflamed joints approximate serum levels; furthermore, intra-articular injection per se may produce a toxic synovitis.

D. Meningitis and endocarditis due to the gonococcus require high-dose intravenous penicillin therapy (at least 10 million units per day) for longer periods: usually at least 10 days for meningitis and 3-4 weeks for endocarditis.

Gonococcal Infection in Pediatric Patients

Pediatric patients encompass those from birth to adolescence. When a child is post-pubertal and/or weighs over 100 pounds, he or she should be treated with dosage regimens as defined above for adults.

WITH GONOCOCCAL INFECTION IN CHILDREN, THE POSSIBILITY OF CHILD ABUSE MUST BE CONSIDERED!

The efficacy of therapeutic regimens for uncomplicated and complicated gonococcal infections of childhood is unproven at present.

Prevention of Neonatal Infection:

All pregnant women should have endocervical cultures examined for gonococci as an integral part of prenatal care.

Prevention of Gonococcal Ophthalmia:

A. One percent silver nitrate (do not irrigate with saline, as this may reduce efficacy).
B. Ophthalmic ointments containing tetracycline, erythromycin, or neomycin are also probably effective.
C. NOT RECOMMENDED: Bacitracin ointment (not effective) and penicillin drops (sensitizing).

Management of Infants Born to Mothers With Gonococcal Infection:

Orogastric and rectal cultures should be taken from all patients. Blood cultures should be taken if septicemia is suspected. Aqueous crystalline penicillin G, 50,000 units/kg/day, should be administered in two daily doses intravenously, if cultures or Gram-stained smears reveal gonococci. The duration of therapy should be determined by clinical response. In suspected septicemia, an aminoglycoside should also be administered.

State psychiatric society adopts position paper

Psychiatrists meet at Host Inn, Harrisburg, October 25.

The Pennsylvania Psychiatric Society at its fall meeting adopted a position paper calling for professional quality care for the mentally ill and retarded in the Commonwealth and emphasizing the need for such care in community mental health centers if the trend toward reduction of patient census in state mental hospitals is to continue. The position paper appears in full in this issue, beginning on this page.

H. Keith Fischer, M.D., psychiatric society president, said that the society plans to revise its position on an annual basis so that current conditions are covered. The meeting took place during the annual educational assembly sponsored by the Pennsylvania Medical Society. The morning business session was followed by a scientific session, "A Clinical Look at the Interface of the Emotional and the Organic."

The society also acted on a request from the Department of Public Welfare for assistance in reviewing a backlog of some 1,700 disputed and denied admissions to community hospitals for psychiatric reasons under medical assistance. Dr. Fischer said members voted favorably on a recommendation from the society's executive council to advise the welfare department to apply criteria for psychiatric admissions prepared by the Pennsylvania Psychiatric Society for the use of the Pennsylvania Medical Care Foundation and for the state's Professional Standards Review Organizations when they become operable. The psychiatric society agreed to assist the department in securing qualified psychiatrists to review those disputes which cannot be resolved in this manner, Dr. Fischer said.

Pennsylvania Psychiatric Society Statement

Fall 1974

Pennsylvania's medical and psychiatric contributions to the public, from the heroic days 200 years ago up to the present, including the modern pioneering of the Mental Health and Mental Retardation Act of 1966, have been characterized by a scientific and humanity oriented professional tradition.

In continuing contribution, the Pennsylvania Psychiatric Society presents a studied input which is offered in our collaborative expanding and ongoing efforts toward treatment service excellence.

This statement could easily consist only of commendable and successful aspects of Pennsylvania's public and private mental health services and activities. Instead, we make certain suggestions and recommendations in areas considered important. Also, we chose to focus on trends, services, policies, and practices which need to be publicly considered because they dilute, compromise or defeat the treatment service excellence we seek. All of them deserve serious attention by those interested in Pennsylvania's mental health services and programs.

1. The Pennsylvania Psychiatric Society has a growing concern for continued small and massive threats to the privacy of individuals—patients, as well as others, on many levels.

A recent bureaucratic order demanded the names of patients in private mental hospitals. The Society protested, was not given adequate reasons, but was told in effect not to worry about it—they would handle things. We have no confidence in this and it happens all too often.

Recently there have been demands to duplicate entire medical psychiatric records of mentally ill patients for determination of whether payment would be made. This is frequently done without specific knowledge of either the patient or his physician. We consider this unnecessary in all but unusual instances. This must be stopped and a more appropriate and equitable determination method developed—including specific patient and physician knowledge and consent.

In a broader sense, the general proliferation of computer banks with information about individuals over which at the present time there is no

(Continued on page 35)

Dreadful dread disease policies back

So-called dread disease policies which capitalize on fear of cancer and other catastrophic illnesses are being marketed again in Pennsylvania. Their port of entry is one of the loopholes in the insurance law which permits out-of-state insurance "trusts" to sell insurance in Pennsylvania with only peripheral regulation by the Pennsylvania Insurance Department.

The climate for dread disease policies in Pennsylvania remains extremely hostile, a legacy of the Denenberg era. In his "Shopper's Guide to Health Insurance," the former Commissioner had this to say about dread disease policies: "Some policies—known as dread disease policies—are so narrow in coverage they pay if and only if you get a certain disease. Usually the disease covered is cancer. Sometimes the policies include other 'dread diseases' such as leukemia, spinal meningitis, rabies, polio, and the like. While not all limited disease policies are exactly alike, none give you the broad coverage you need and want. When you buy these policies, you're not insuring, you're gambling."

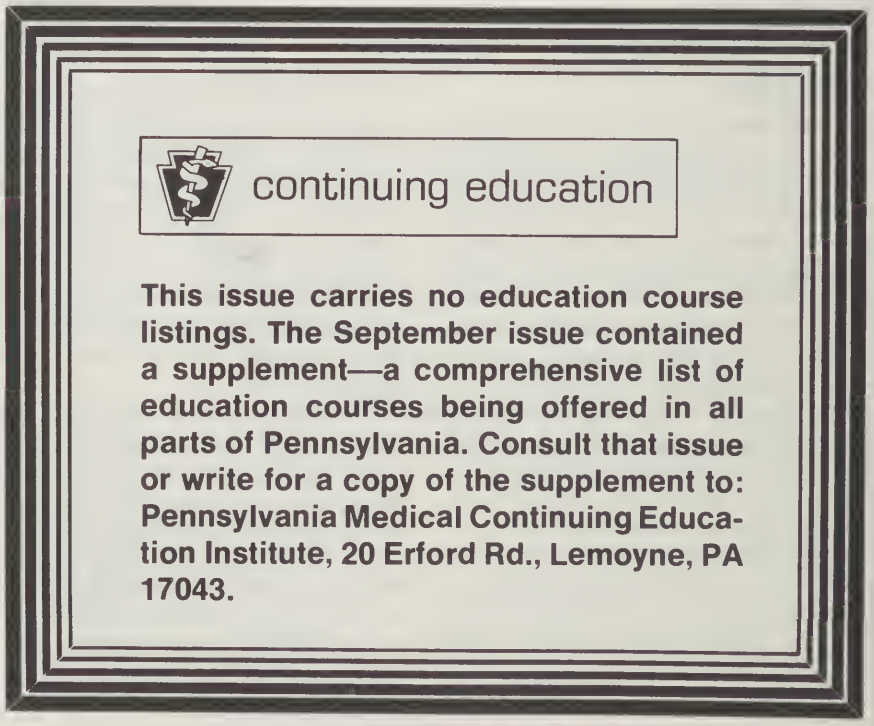
One policy now under study for cancer, heart disease, and stroke is sold by the Select Physicians and Surgeons' Insurance Trust. This coverage, underwritten by the Continental Casualty Company and administered by Daniels-Head & Associates of Portsmouth, Ohio, appears to be specifically tailored for physicians. At a glance, this promotion can be mistakenly interpreted as an endorsement by organized medicine, which in fact it is not.

In Pennsylvania, the Denenberg Insurance Department put out a regulation prohibiting companies from issuing dread disease policies. It was Denenberg's feeling that mass-marketed policies of this sort were "junk" and "nothing short of fraud." In response, the American Family Insurance Company of Georgia, whose sole market in Pennsylvania is dread disease-type coverages, secured a temporary injunction against the department. A legal battle ensued with the department finally backing off. However, before leaving office, it is believed that Denenberg issued instructions not to approve any new dread disease policies. It would appear that such a directive is still in effect.

According to Daniels-Head & Associates, Inc., the dread disease coverage for cancer, coronary disease, and stroke being offered to Pennsylvania physicians is not a dread disease coverage "in that the protection offered protects those insured persons against most of the illnesses that can keep them from practicing medicine for an extended period of time."

Society officials point out that coverage in the Select Physicians and Surgeons' Insurance Trust has no relationship to the length of disability. For example, the average length of stay in a hospital (the only setting in which this policy will pay) for heart disease is in the area of twenty-one days. Most cerebral vascular accident victims leave the hospital within fourteen to twenty-one days. Patients recuperating from these diseases may spend months and years in nursing homes or in their own homes unable to practice their profession. As long as the dread disease policy limits itself to hospital stays, it would appear to cover a very small portion of such catastrophic risks.

The Pennsylvania Insurance Department only has regulatory authority with respect to the advertising of out-of-state insurance trusts. The Pennsylvania Medical Society and the department are working together to eliminate several instances of misleading advertising and will continue to police this area in the future.



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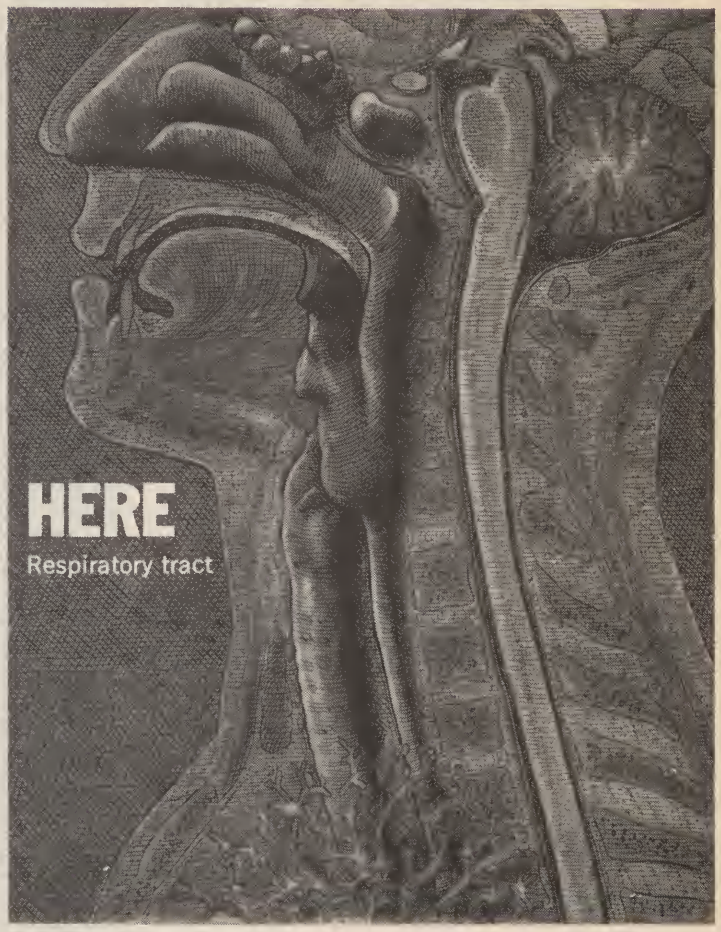

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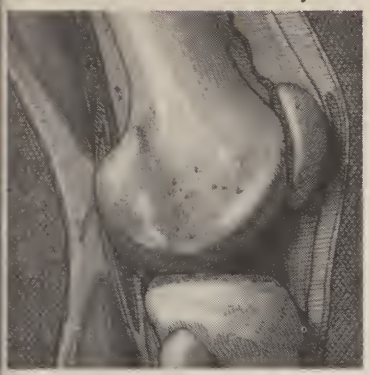

Wherever it hurts, Empirin Compound with Codeine usually provides the symptomatic relief needed.

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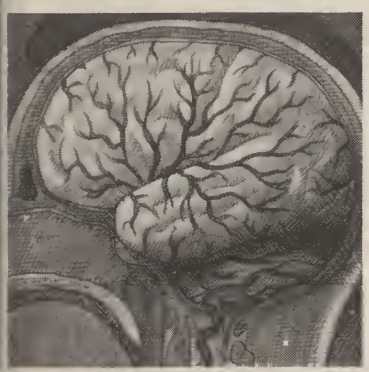

In flu and associated respiratory infection, Empirin Compound with Codeine provides an antitussive bonus in addition to relief of pain and bodily discomfort.

℞ **prescribing convenience:** up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

Empirin Compound with Codeine **No. 3**, codeine phosphate* 32.4 mg. (gr. ½); **No. 4**, codeine phosphate* 64.8 mg. (gr. 1) *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

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Opinion & Dialogue

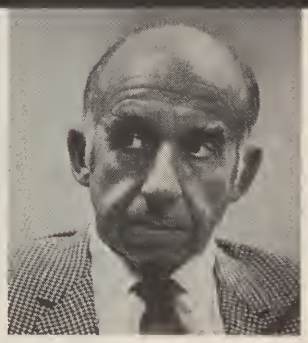
The Role of the Detail Man

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

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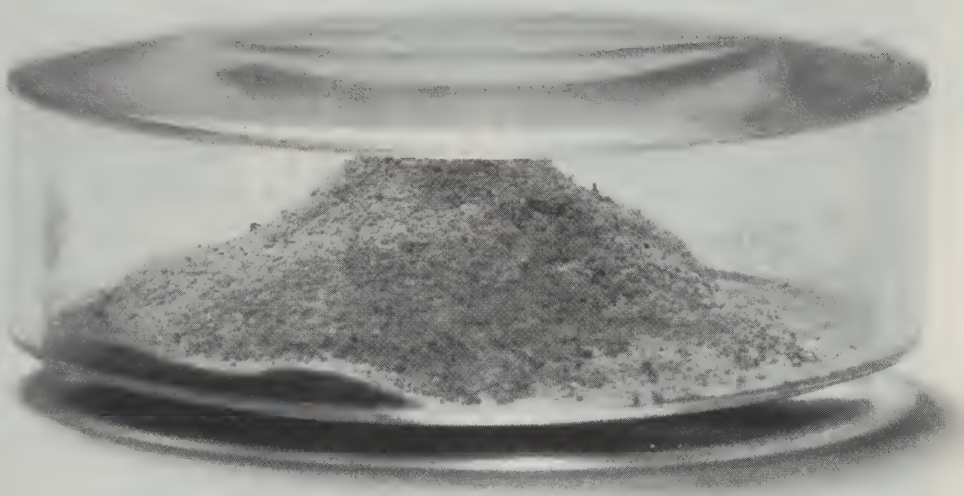

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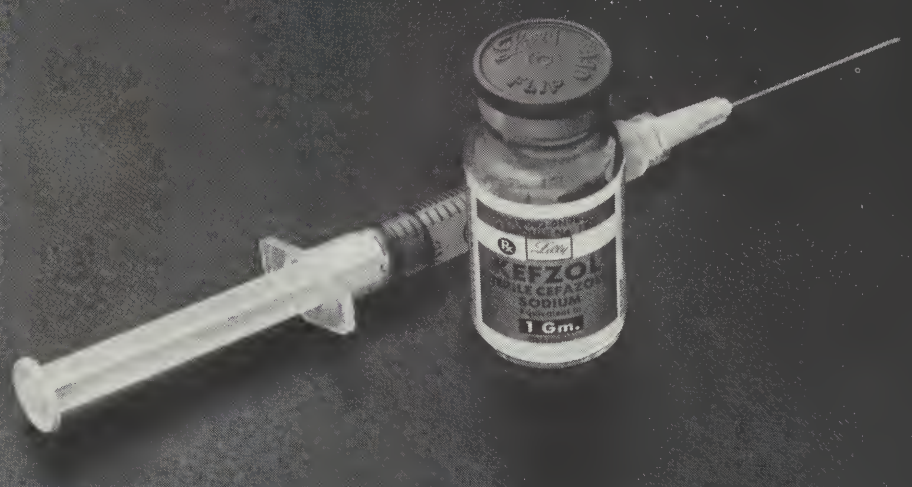

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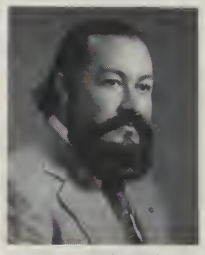
MDs in the news

Edgar L. Ralston, M.D., chairman of the department of orthopedic surgery at the University of Pennsylvania School of Medicine, has been selected first incumbent for a new professorship of bone and joint surgery bequeathed in honor of the late Dr. Paul B. Magnuson by his widow. The professorship will give special emphasis to industrial and traumatic medicine and surgery. Dr. Magnuson was former chief medical director of the Veterans Administration Services.

The Philadelphia Psychiatric Center has opened a new Human Development Center in the greater northeast section of Philadelphia and has named **Gaston-Germain Trigos, M.D.,** psychiatrist, as clinical director. Dr. Trigos was formerly executive director of the Northeast Community Mental Health Center. He is a diplomate of the American Board of Psychiatry and Neurology and is a clinical assistant professor of psychiatry at Hahnemann Medical College. The new center will have all of the same outpatient services now available at Philadelphia Psychiatric Center.



DR. TRIGOS

DR. ZATUCHNI

Jacob Zatuchni, M.D., has been promoted to director of the department of medicine at Episcopal Hospital, Philadelphia. He is a professor of medicine at Temple University School of Medicine.

Paul L. Carmichael, M.D., Lansdale, has been appointed visiting associate professor of nuclear medicine at Hahnemann Medical College and Hospital. He is chief of ophthalmology at North Penn Hospital and is affiliated with Wills Eye Hospital as an associate surgeon and a consultant in nuclear medicine.

Milton M. Auslander, M.D., received the first Distinguished Physician's Award from Sacred Heart Hospital, Norristown. He is a member of the Academy of Ophthalmology and Otolaryngology and the American Society for Plastic and Reconstructive Surgery.

Daniel E. Wolfe, M.D., has been honored with the presentation of a plaque by the Penns Valley Area Medical Center in appreciation of his services to the people of the Penns Valley area. He is presently serving a three-year radiology residency in Rochester, N.Y.

Joseph E. Green II, M.D., Carlisle, is the recipient of the Ethical Standards Award of the Carlisle Rotary Club. Dr. Green is a past president of the Cumberland County Medical Society and is an emeritus director of the Cumberland County Tuberculosis and Health Association.

James P. Boland, M.D., former associate professor of thoracic surgery at Medical College of Pennsylvania, has been promoted to professor of thoracic and cardiovascular surgery. Dr. Boland is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He is a fellow of the American College of Surgeons, the American College of Chest Physicians, the Society of Nuclear Medicine, and the Pan American Medical Society.

Francis E. Rosato, M.D., professor of surgery at the University of Pennsylvania School of Medicine, and chief of the solid tumor program in the department of surgery, has accepted a position as professor and chairman of the department of surgery at the Eastern Virginia Medical School, Norfolk, Va., effective July 1, 1975. Prior to assuming his new position, he will spend six months in Paris, France, studying in the area of tumor immunology. Dr. Rosato will continue to direct the immunotherapy laboratory at the Hospital of the University of Pennsylvania.

Two York Hospital physicians have been appointed division chiefs recently. **Floyd L. Harris, M.D.,** is the new chief of anesthesiology. He has been associated with York Hospital

DR. HARRIS

DR. WIBLE

since 1961. **Claire E. Wible, M.D.,** is the new chief of ophthalmology. Both physicians are board certified in their specialties.

Herman Gold, M.D., Media, and **Daniel Marino, M.D.,** Wallingford, were honored recently for their work in cardiology at the Crozer-Chester Medical Center when a ball was given. The proceeds were slated for the purchase of equipment for the cardiac care unit. Dr. Gold became chief of cardiology in 1972. He has been succeeded as director of the division by Dr. Marino.

Samuel B. Hadden, M.D., Wynnewood, has recently returned from Athens, Greece, where he attended the International Congress of Social Psychiatry and presented a paper. He also addressed two clinics in London and at the University of Aberdeen School of Medicine in Scotland.

Robert Zelis, M.D., from the University of California Davis School of Medicine, has been named professor of medicine and physiology and chief of the division of cardiology at Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center. He is a fellow of the American College of Cardiology, the American College of Chest Physicians, the American College of Physicians, and the International College of Angiology. He is also national councillor of the American Federation for Clinical Research.

York-Young Wong, M.D., has been appointed attending physician in physical medicine and rehabilitation at the Moss Rehabilitation Hospital and the Albert Einstein Medical Center. He was previously an assistant instructor in the department of physical medicine at State University of New York, Downstate Medical Center.

DR. WONG

DR. GOLDSCHMIDT

New 1974-75 president of the Philadelphia Dermatological Society is **Herbert Goldschmidt, M.D.**, of Gladwyne. He is associate clinical professor of dermatology at the University of Pennsylvania School of Medicine and is chairman of the task force on ionizing radiation of the National Program for Dermatology of the American Academy of Dermatology.

Larry L. Ackerman, M.D., and Ugo Goetzl, M.D., have joined the Pennsylvania State University College of Medicine at the Milton S. Hershey Medical Center as assistant professors. Dr. Ackerman was formerly chief of psychiatric services at the Loring Air Force Base Hospital in Maine. He is a member of the American Society of Adolescent Psychiatry. Dr. Goetzl was formerly staff psychiatrist with the mental hygiene consultation service at Madigan Army Medical Center, Fort Lewis, Washington. He will also serve as assistant director of the psychiatry residency training program.

Walter I. Buchert, M.D., Pottstown, was honored for his leadership of the Institute for Medical Education and Research at Geisinger Medical Center at a recent alumni association meeting. The first published annual report of the institute was dedicated to him. Dr. Buchert is senior consulting medical director and president emeritus of the institute and was its first president. He is a member of the board of trustees and a past president of the American Association of Medical Clinics and is on the National Advisory Committee of the Robert Wood Johnson Foundation. Dr. Buchert is certified by the American Board of Urology, a member of the American Urological Association, and a member of the American College of Surgeons.

Charles A. Laubach, Jr., M.D., Danville, has received the American Heart Association's Distinguished Achievement Award presented by the association's Pennsylvania Affiliate. He is chief of cardiovascular medicine at Geisinger Medical Center and associate clinical professor at the Milton S. Hershey Medical Center, Pennsylvania State University. He has served the organization for eighteen years in many capacities, including that of president. **Lee H. Shields, M.D.**, Harrisburg, outgoing president of the state affiliate, received a Distinguished Service Award.

Frederick S. Share, M.D., Pittsburgh, has been appointed director of the newly formed cancer treatment center at Divine Providence Hospital. He is attending physician in the department of radiation oncology at Allegheny General Hospital and is a diplomate of the National Board of Medical Examiners and the American Board of Radiology in Therapeutic Radiology.

Maurice Albin, M.D., professor of anesthesiology and neurological surgery at the University of Pittsburgh School of Medicine, headed a university research team that has produced a drug compound, tetrahydroaminoacridine (THA) that shows promise of reducing withdrawal symptoms of morphine; reversing the hallucinogenic effects of the street drug, phencyclidine; and decreasing the side effects of the anesthetic agent, ketamine. He announced the team findings at the European Congress of Anesthesiology in Madrid, Spain, recently.

George C. Potash, M.D., Lebanon, has been named a director of the Pennsylvania Academy of Ophthalmology and Otolaryngology. He is certified by the American Board of Ophthalmology and is a member of the American Association of Ophthalmology.

The Pittsburgh Regional Council of Child Psychiatry, an affiliate of the American Academy of Child Psychiatry, has elected the following officers for the 1974-75 year: **Naomi Ragins, M.D.**, president; **Jack Reinhart, M.D.**, president elect; **Alan Axelson, M.D.**, secretary; and **Frank Donovan, M.D.**, treasurer.

New officers have been installed by the Pennsylvania Affiliate of the American Heart Association. **Irvin Jacobs, M.D.**, Dallas, the new president, is a family practitioner on the pediatric staff of Wilkes-Barre General Hospital. **Harry Goldberg, M.D.**, Philadelphia, was installed as president elect. He is director of the cardiovascular section at the Albert Einstein Medical Center and professor of medicine at Temple University School of Medicine. He is also director of Einstein's cardiopulmonary renal laboratory. Vice presidents include **Frank R. Begg, M.D.**, Pittsburgh, and **Stephen B. Langfeld, M.D.**, Philadelphia.

Thomas Behrendt, M.D., professor of ophthalmology at Jefferson Medical College, Thomas Jefferson University, has been appointed to the board of directors of the Pennsylvania Diabetes Institute by Governor Milton J. Shapp.

DR. BEHRENDT

DR. SOLL

David B. Soll, M.D., has been named professor and chairman of the newly formed department of ophthalmology at Hahnemann Medical College and Hospital, Philadelphia. He is director of the departments of ophthalmology at Rolling Hill and Frankford Hospitals and at the Philadelphia Geriatric Center. He is a member of the National Committee of Trauma of the American College of Surgeons, a medical advisor to the American Society of Ocularists, and a charter member of the American Society of Ophthalmic Plastic and Reconstructive Surgery.

editorials

Yes, Santa, there still is a Virginia

When we become adults, we tend to forget the ideas and beliefs we had as children. Christmas is a time when many happy childhood memories are revived—especially those of decorating the tree, family get-togethers, good cooking aromas, candy canes, gift giving, and Santa Claus. Remember how you used to write letters to Santa and how you left a snack of cookies and milk on the kitchen table before you went to bed? It is highly unlikely that you would consider writing letters to Santa today; but if you did, it might look something like this:

Santa Claus
North Pole

Dear Santa,

You probably don't remember me because I last wrote to you forty years ago, but there are some things I'd like to request and I thought perhaps you could use your influence to get them.

During this next year, I would like to accomplish the following:

1. Save one patient who has been given up for lost.
2. Improve the quality of survival of as many people as it is within my power to do.
3. Inspire at least one young physician.
4. Find more time to spend with my family.
5. Pass my specialty boards or recertification/relicensure exams.
6. Play one golf game 15 under par.

I would also like to see the following accomplished:

1. More physicians in positions of governmental leadership for health.
2. Separate federal department of health with a full-time cabinet level secretary.
3. No reimposition of cost controls on health.
4. Good judgement and restraint exercised in the formulation of impending national health insurance.

Any assistance you can give in fulfilling this list will be appreciated.

Merry Christmas.

David A. Smith, M.D.
Medical Editor

It's like Alice in Wonderland

Reprinted from Lackawanna Medicine

It has become a topsy-turvy medical world where responsibility and authority have become severely disjointed and lay groups and paramedical personnel have been given or have taken power without the advice or consent of the medical profession.

Just a few weeks ago I personally had a patient in the hospital with thrombophlebitis in her left leg. She was in the process of being anticoagulated, and as you all know, at times the adjusting of anticoagulants may be quite difficult. On June 26 the following note was placed on the front of my patient's chart and signed by a nurse: "Dr. Demko, this patient will have to be discharged by the twenty-eighth unless you change the diagnosis and ask for an extension. Thank you. Signature, R.N." Plainly the decision to continue or not to continue hospitalization despite the validity of my judgment was being usurped by a nonphysician who patently had no responsibility in this case.

I received a list of charges that are accepted as reasonable by the state of Pennsylvania for home visits by Visiting Nurses Association. Minimum charge for a home visit is $12.00. Physicians, on the other hand, are paid $7.00 for a house call.

It happens that I am on the board of directors of the Pennsylvania Medical Care Foundation, the advisory body to the state PSROs. The federal government has stated that it will pay for PSRO activity except that it will not pay members of the board of directors for their time expended as directors which is an essential element of any PSRO. Oh! They will pay the lay people involved; they will pay the lay executive director, but they

will not pay the directors for their expertise, which is essential for the running of a successful organization.

I recently received the bylaws of one of our city hospitals. In the bylaws of the medical staff, the executive director (hospital administrator) was named approximately one dozen times. He is not even a member of the medical staff. The board of directors was named even more often, whereas the chief of staff was named approximately ten times. The preamble to the bylaws states (quite incorrectly interpreting the Darling decision) that the medical staff is "subject to the ultimate authority" of the board of directors. However, the responsibility for the "quality of medical care" resides with the medical staff. Authority without responsibility heralds the most horrendous consequences for medicine not only in our community but in the entire nation. Authority without knowledge and expertise is ludicrous.

This is where things stand today in our community, in our state, and in our nation. If you think that it will go away without the positive action of all of us in the medical profession, you are badly mistaken.

Over the past eight months your officers and your committees have tried to organize in as efficient a manner as possible so that your society can become a manageable organization for your use in combating this "Alice in Wonderland" approach to the health care system of this great nation. Please, I beg you, use it!

Joseph N. Demko, M.D., President
Lackawanna County Medical Society

Did the doctor help your headache?

practice management

Doctors benefit from Pension Reform Act —part two

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Last month we mainly explored the effects of the Pension Reform Act of 1974 on medical practices other than in the traditional professional corporation form. They consisted of changes in Keogh plan rules, the establishment of new "individual retirement accounts" (IRA's), and of improvements in a modified corporate form known as "subchapter S" corporations.

This month we hope to provide some background for our readers who are incorporated and thus are concerned about the Act's impact on their retirement plans and benefits anticipated thereunder. In the course of this discussion, of course, the article should be similarly useful to those people presently considering converting to professional corporations.

1. Limits on Contributions—An incorporated doctor's main question about the Act is undoubtedly whether it will affect the *amounts* which may be contributed to his retirement plans. In most cases the answer will be "no" although extremely high-income physicians will in fact become restricted.

Most professional corporations, and almost all those under our advice, maintain plans which the new Act calls *"defined contribution plans."* These may be either profit sharing plans or "money purchase" pension plans or both, neither of which depends upon employee ages or actuarial input. As to such defined contribution plans, the maximum amount which may be contributed for any employee in a year is essentially the same 25 percent of total corporate compensation as in the past.*

There is, however, a new dollar limit imposed upon contributions for any one employee under such a plan or plans. Not more than $25,000 may be contributed regardless of the percentage involved. The net effect, of course, is to limit the amount which may be contributed for an employee whose salary is over $100,000.

Those doctors participating in the other type of retirement plans, now called *"defined benefit plans,"* are even less affected by the Act. These are the plans which we have in the past called "fixed benefit pension plans" and which rely both upon variations in employees' ages and upon rather complex actuarial principles. In these situations, the new limit is expressed as a function of what each employee's actual pension will be when he retires. His pension benefit may not exceed the *lesser* of $75,000 per year or 100 percent of the average of his highest three years of salary. The amount which may thus be *contributed* for an employee-physician each year will, of course, depend on his age, but we doubt that this new limit on *benefits* will adversely affect the amounts being contributed for most doctors in "defined" or "fixed" benefit pension plans.

The new Act is particularly generous in permitting both dollar limits ($25,000 for defined contribution plans, and $75,000 for defined benefit plans) to be adjusted annually to reflect increases in the cost of living. The measuring period is the calendar quarter just ended December 31, 1974; and hence if in 1975 the selected index is 10 percent higher, we presume the following year's limits would also be 10 percent higher. The adjustment rules are to be developed by the Treasury Department in regulations which will probably not be proposed or adopted for many months.

There are also special rules applying to corporations which might adopt both a defined benefit and a defined contribution plan. Since some professional corporations have found this to be a desirable combination, these special rules are important to some doctors. Furthermore, the extremely high income physician who is perhaps fifty years old or older might find such a combination to be a means of setting aside more than the $25,000 defined contribution figure each year.

So long as the corporate plan itself was in full effect before the Act became law, these new rules will not become effective for a considerable time. They will first apply to the corporation's fiscal year beginning after December 31, 1975. If a doctor's corporation is on a June 30 fiscal year, therefore, no changes would be required as to contributions or benefits until the year which begins July 1, 1976, and ends June 30, 1977. Any plans now or hereafter adopted must, of course, conform to the new rules in order to be approved by the IRS.

2. Eligibility - Who must be Covered—Pension experts have generally been alarmed that the Act's new rules on eligibility will be costly

**The contribution limit for a profit sharing plan by itself is, as before, 15 percent of the covered employees' compensation. Thus, to achieve the 25 percent maximum, a profit sharing plan will have to be combined with a money purchase pension plan.*

Your existing pension plan has been affected by the enactment into law of the Pension Reform Act. This article is the second part of an explanation to help you understand this important and complicated legislation.

to most employers, but that fear does not extend to most professional corporations. We believe, in fact, that the new eligibility rules are generally quite favorable to our clients.

Under the new rules, for a person to commence plan participation, a plan must not require his employment beyond the *later* of (a) one year of employment, or (b) his twenty-fifth birthday. Virtually every professional corporation presently has far more liberal eligibility rules already and hence the new provisions will normally be highly satisfactory. It is not yet clear whether such existing corporations will be allowed to amend their plans to fit the new rule if to do so would be contrary to present or future aides' interests (which would typically be the situation among professional corporations). At any rate, the rule changes in this regard are certainly not cause for serious change in any physician's thinking about present or future corporate arrangements.

There is an alternative eligibility rule which might become valuable to professional corporations. Under it, a plan may exclude any employee from participation for up to three years after his or her employment if his or her benefits are thereafter always "nonforfeitable." This is equivalent to the present Keogh rule which so often permits a doctor to exclude one or several of his short-term aides from Keogh participation. Since upon incorporation, however, a doctor is as new an employee as his aides, a three year waiting period would cut against him as well—explaining why professional corporation plans invariably cover employees with only a few months of service.

Several recent court decisions have ruled that a person's service as a sole proprietor or partner may be counted as "service" when that business or practice incorporates. If this should become established firmly in the law by more decisions, or if it should be accepted by the IRS in its regulations, then the three year waiting period alternative would become significant to new professional corporations. A doctor could then incorporate and continue the same three-year waiting period he might currently have in his Keogh plan. It is premature to assume this development except for a doctor who is willing to have the question taken to court, but we hope the IRS will adopt the newer posture.

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Doctors must also be aware that the Act has in effect imposed a new definition of "full-time" employment. Both corporate and Keogh plans have traditionally excluded all part-time employees by requiring a person's "customary employment" to be at least twenty hours per week during at least five months of the year. This definition was subject to considerable misinterpretation and/or abuse. Under the Act, however, any person employed for 1,000 hours in the year must be treated as having a year of service.

This new 1,000 hour rule will probably pull into pension participation a variety of medical practices' marginal aides. It will also cause a practice to keep rather careful records of cumulative hours worked by part-time employees who are not intended to be in the retirement program.

As to plans in existence before the beginning of 1974, these new rules will similarly not apply until fiscal years beginning after December 31, 1975. Any plans adopted during 1974, and obviously any plans hereafter drawn, must meet the new rules.

3. Vesting Requirements—Just as with eligibility, the Act has actually improved matters for most professional corporations insofar as "vesting" is concerned. Existing law had left it to each local IRS office to determine whether a corporation may establish a certain vesting schedule, the criterion in each case being whether that schedule might be "discriminatory" against the lower paid, non-supervisory employees—the aides. In almost every case involving small medical corporations, the IRS required vesting over a fairly fast

schedule because of the presumed turnover rate among aides.

A "vesting schedule," by the way, is simply the schedule of time over which a person's financial interest in the plan would be irrevocably his or hers even if that person should then leave the practice for another job. It is the schedule over which an employee's plan account becomes "nonforfeitable," using the Act's new term for vesting. The schedule must, of course, be the same for all employees of a company—both the doctors and the aides.

Since most large commercial companies were able to maintain plans with almost no vesting until actual retirement, Congress felt the need to legislate specific minimum vesting schedules. These new schedules are, however, less restrictive than professional corporations had typically been allowed to establish. Hence, the Act allows most medical practices to extend considerably the time before an employee's plan interest must be "nonforfeitable." Since amounts forfeited when an employee leaves the practice usually inure either directly or indirectly to the benefit of the doctors, the new vesting provisions are generally favorable to professional corporations.

No useful purpose would be served here by explaining the three alternative vesting schedules authorized by the Act. Suffice it to say that under one of them, the "rule of 45," a doctor age fifty might be fully vested even if only with the corporation for a couple of years. His newly hired aide who is thirty-five years old might not, however, become fully vested for another ten years. This could not have been accomplished before the Act, but such are the strange workings of pension law.

The three new alternative vesting arrangements are merely minimum standards all plans must meet. No one of the three is uniquely the best for all medical practices, and hence each incorporated doctor will have to consider with his advisors which choice to be made for his own plan. Furthermore, many professional corporations will wish to maintain their present schedules rather than

. . . and I think it's a bone of contention!

amend downwards to meet the new minimum rules. For instance, a fair number of small medical corporation plans provide for immediate or nearly immediate full vesting since the doctors themselves want to assure that their own interests will not be forfeited if any of them should change employment. Taking advantage of the Act's new rules would not be desirable in such situations.

4. Funding Requirements—"Defined benefit" plans, the type which require actuarial calculations, have always been much more complicated to handle than our preferred "defined contribution" plans. The Act has now increased still further the complexity of defined benefit plans to the point that we are flatly opposed to their use in all professional corporation cases unless there are overwhelming economic advantages involved. The various new funding requirements for defined benefit plans will thus not be discussed in this article.

The new law does provide a new break in the timing for making tax deductible contributions to any type of plan. It permits all employers, including those on a cash basis of accounting to make and deduct contributions for a year even after that year has ended. They will still be deductible if made within a "grace period" which runs until the date for filing the corporation's income tax return for that year (including extensions). This will be a real break for physicians and their advisors since almost all medical practices operate on a cash accounting basis. It should reduce somewhat the very difficult year-end calculations of pension and profit sharing contributions which were so often mere guesses made before real accounting information was actually on hand.

In taking advantage of the new "grace period" rule (which, by the way, does not become effective for several years in the case of pre-existing plans), doctors and their advisors should be careful to avoid a possible tax trap. In any profit sharing plan calling for annual decisions on amounts to be contributed (a "discretionary" profit sharing plan), the *liability* must be established before the year actually ends if a grace period contribution is to be deductible. The IRS maintains that this liability is created only when the board of directors has authorized the amount to be contributed *and* the undertaking has been communicated to the employees concerned. Therefore, if a medical corporation decides to delay contributing until the grace period, it should be sure these two steps have been taken *in writing* (for proof in case of an IRS audit) before the fiscal year ends.

5. Fiduciary Standards—One of the main reasons for the Act's adoption had been reports of widespread misuse of corporate retirement funds. The employing companies

and persons who controlled those companies had too often caused the trust funds to be used for purposes not particularly for the "exclusive benefit" of the employees covered by the plans. Therefore, a very strict new set of fiduciary standards have been set forth and they will be enforceable by the U.S. Department of Labor as well as by the IRS.

The new law broadly defines "fiduciary" to include any person who exercises any discretionary control with regard to the management or administration of the plan of its assets, or who renders investment advice to the plan for a fee or other compensation. These people will be subject to a strict "prudent man" rule in the discharge of their duties. For example, the plan fiduciaries must diversify the plan assets so as to minimize the risk of large losses, unless it would clearly not be prudent to do so under the circumstances. This will cause serious question whether a small corporate plan may, for instance, invest most of its moneys in a piece of land or a single stock—an approach taken by quite a few doctors' plans to date.

A fiduciary who breaches the fiduciary standards may be subject to personal liability for the breach. Furthermore, a co-fiduciary could also become liable for the other's breach unless he exercised his own efforts to stay informed and make his own decisions. Simply put, more care than ever must be exercised in this area; it becomes imperative to seek expert advice before taking any steps that are even slightly questionable since the potential for civil liability is present. The Act also makes any provisions in the plan or trust agreement relieving a fiduciary from responsibility for breach of his duties void and ineffective.

Along with the general requirements of fiduciary care, the Act sets forth a specific list of absolutely "prohibited transactions." Under this list, a pension or profit sharing fund may under no circumstances enter into these deals with a "party in interest": the sale of any property; the leasing of any real estate or equipment; the lending of cash or credit; etc. And the list of persons defined as "parties in interest" is long enough to include almost anyone closely tied to the corporation: the corporation itself; its officers, directors, 10 percent or more shareholders or highly paid employers; certain family relatives of such persons; and commonly controlled separate businesses; etc.

Suffice it to say that any doctor considering some special use of his corporate (or Keogh) retirement fund should be sure to clear it with his advisors before doing so. The old ideas of having his plan purchase land for the corporation's new medical building, of having his plan invest in a mortgage on his own home, etc. should now be taboo.

There is one major exception by which a doctor might still make some personal use of his retirement fund. A trust may still lend money to a participating employee even if he is a "party in interest." However, such loans must be available to all participating employees on a nondiscriminatory basis (including the amounts made available for borrowing which need not be restricted by the participant's vested interest in the plan), must bear a reasonable rate of interest, and must be adequately secured.

A physician should not read much real opportunity into this borrowing permission. To comply with the Act, any such loan must be repaid within a reasonable period of time, and any signs of self-dealing might spell real trouble. Therefore, unless a physician is willing to treat the loan from the plan as he would a loan from a bank, then we urge that he not borrow from the plan. If he considers his borrowing from the plan a convenience to himself, we have rarely found his thereafter paying it back to be a convenience. We consider it preferable for a doctor to assume the money is absolutely unavailable so he will resist any temptations which could lead to greater trouble.

6. Disclosure Requirements—The Act calls for extensive additional reporting to both the IRS and the Labor Department. These requirements are not of a substantive nature but will result in additional procedural burdens on plans and their advisors. Some of the new rules, by the way, require information being submitted periodically to all employees participating in the plans—something which small professional corporations have typically ignored in the past. All plans must comply with the various new reporting provisions, whether one employee or thousands are involved.

In addition to the details these new requirements impose, they will undoubtedly add considerably to the costs of administering retirement plans. Where the plans are trusteed by banks, we would assume their compensation schedules will have to be increased. Where the plans are trusteed instead by individuals (usually the doctors themselves), the fees charged by accountants and pension administrative companies will similarly be increasing.

7. Conclusions—This article has barely scratched the surface of one of the most complex pieces of legislation written. Despite that complexity, however, the Pension Reform Act will not usually present overwhelming problems to any but a handful of incorporated physicians. It may discourage some marginal-income physicians from incorporating, since the Keogh plan alternative is so improved; but most doctors should find it no serious factor in deciding whether to incorporate.

Finally, the Act's many provisions will require every existing plan (both corporate and Keogh) to be amended extensively. Some of these amendments may be required in the near future, while others may be deferred for upwards of two years. Lawyers' efforts involved in amending each plan and then having each revised plan approved anew by the IRS will be time-consuming and costly. Since the work and expense involve little that is seriously adverse to medical corporation, however, we believe they should be tolerated with a sense of relief. Considering how severely early drafts of the Act would have treated professional corporations, the end result is a good one.

State psychiatric society adopts position paper

(Continued from page 17)

control and the use of this data by public officials and others demands that broad legislative action be undertaken to supervise, control, limit to appropriate persons, and insure that accountability be established in each of these areas. We applaud and support present legislative efforts to define and insure patient/psychotherapist confidentiality.

2. A concern for the patients' humanity involves human dignity, rights to privacy, appropriate confidentiality, and civil and legal rights. This consideration is not only moral, but important and necessary for good treatment. These rights must be available and safeguarded. They must be worked out to accommodate the best treatment in the most appropriate manner possible. The establishment of review and advocacy systems may assist in this goal, but must in themselves be subject to safeguards of both individual and community rights.

3. In the community mental health centers and programs that have developed since 1966 we see much that is good but also much that is cause for concern.

(a) There are serious gaps in the treatment services, delivery, and its system of administration. Public treatment services and private treatment services are increasingly separated. Continuity of care is frequently lacking. In the public area, increasing monetary charges to patients are making it too expensive to use these services for low income people who are not on public assistance. This leads to risk of exclusion of these people from public treatment services. In addition standards, accountability, and evaluations for results and costs should be determined in both the public and the private treatment service areas. The 1966 Act mandated this in the public area, but it has never been adequately and completely implemented.

(b) Another problem results from the manner in which some public administrative activities and some treatment services are moving toward social and political domination and further away from leadership of mental health professionals. Some nonmedical people, at times validly critical of restricted or "super-specialized" medical and psychiatric professionals, have at other times created for a variety of reasons of their own, a stereotype so-called "medical model" which they deride, ridicule, and declare outmoded. Meanwhile, their frequent attempt is to push aside and downgrade the medical and psychiatric contributions rooted in broad based biological, psychological, and social determinants. They wish to substitute their own restricted views and sometimes social and political activism as an alternate solution. With this imbalance in effect the patient, the public, and the professionals interested in mental health services are set backwards. Destructive consequences—as seen by massive precipitous experiments in California, New York, and other places can be avoided if we profit by others' experiences and correct our own situation in time.

(c) Some lay organizations and some state planners are promoting schemes to remove patients abruptly from Pennsylvania's state mental hospitals into the community. The state planning, already said to have cost between $500,000 and $1,000,000, has progressed at times with secrecy (the Bolton Associates were instructed at times with whom not to talk) and often with exclusion of broad factual studies and experienced clinical and professional input. We have reason to believe that some of this continues. However, a present and new planning effort gives hope for better balanced input even though the factual base is still lacking in some areas, and the intended goals often seem already to have been decided. We condemn these *a priori* administrative tactics in approaching so vast a project.

The Pennsylvania Psychiatric Society favors a comprehensive study of the community mental health centers and programs, their patients, their treatments, their therapeutics, and their costs. In the area of therapists we are including psychiatrists, as well as other therapists. The Society offers to assist independently in determining the roles and contributions of psychiatrists in treatment activities as part of this overall study. Furthermore, in each catchment area the need for inpatient hospital and other residential treatments, whether in the public or private service areas, needs to be determined in the light of local resources and developing treatment efforts and results. Improved care for discharged hospital patients is necessary. However, we have learned from other states that precipitous and massive discharge prematurely from hospitals into communities without resources and facilities cannot be tolerated. This scheme becomes a cruel hoax when preemptorily ordered without assurances of consequences by those in control of public monies.

Patient treatment concern, responsibility, and accountability safeguards are essential. They cannot be appropriated at whim and will.

(d) Gaps exist in the incomplete and inadequate treatment service to children and youth, the elderly, and to the chronically ill. Input from psychiatrists and other specialists in these areas will shortly be available for consideration in these program service areas.

4. A scheme called the "single entry" system proposes that no patient can be sent to a hospital (or presumably to any other public or community treatment program) except by a single admission source controlled by the community mental health center or program. This "admission office" or person need not be a physician or psychiatrist, although presumably diagnosis and treatment plans are involved. How can this be any possible advantage to the patient? Why is it proposed?

The Pennsylvania Psychiatric Society thoroughly and completely opposes this plan. This decision of treatment planning requires profes-

sional and expert input. In addition, both public and private professional therapists should have equal freedom of entry to service resources for their patients who need help. To exclude is not a prerogative of administrative or lay leadership.

5. (a) There is evidence that in some instances patients have been influenced or pressured away from private psychiatric treatment and that unwitting patients have been coerced from hospitals into the community mental health system. It is difficult to determine how widespread this is. However, whenever it occurs this is an abuse of the government's power, authority, and money. It makes a mockery of the welfare and rights of both patients and public. It must be stopped.

(b) Recent study shows that in certain community mental health centers and programs, study, diagnosis, and treatment are carried on completely without physician psychiatrists. While many treatment contributions from mental health professionals in psychology, social work, and nursing have their place, each has separate as well as overlapping expertise. If the community mental health center and program includes medical areas without proper licensing, professional and clinical qualifications, and standards, this treatment service is a deception and deviation that cannot be supported—legally or morally.

Is this the evolving public mental health center and program model? The Pennsylvania Psychiatric Society cannot agree that it should be so.

6. Along with this criticism of certain treatment services, a similar and related thrust has been to remove the requirement that the superintendent of a state mental hospital be a physician. Where treatment and clinical considerations are paramount, an alternative leadership is being proposed. This leadership would be determined by social and political considerations. The same criticism applies to numerous administrative and board structures where the diminution or abolition of professional input is a frequently observed trend.

The Pennsylvania Psychiatric Society deplores this trend and imbalance and calls for a return to an appropriate fitting together by recognizing, supporting, valuing, and demanding leadership from mental health professionals.

7. The 1966 Act did not integrate the state mental hospitals with the community programs. Recently some current planners have suggested that the state mental hospitals be abolished altogether. The Pennsylvania Psychiatric Society knows that along with newer short-term treatments, the state mental hospitals have an essential treatment contribution in the care of intermediate illness, and especially in long-term care. The state hospital must be integrated closely with the community resources, both public and private. Furthermore, the contribution of each state hospital may vary depending on the resources of each catchment area. No blanket directive can answer the question of treatment need. But outmoded, duplicating, or unneeded facilities cannot be continued or justified.

8. In the long needed study of cost and accounting, the Pennsylvania Psychiatric Society thinks that economy, savings, and elimination of expensive and unnecessary duplications can result from integrating private resources, personnel, agencies, and institutions vis-a-vis the public program by the means of appropriate contracting.

The Psychiatric Society also deplores the so-called administrative "SINGLE STREAM" funding. This means putting mental health, mental retardation, institutional, and community mental health monies together. In "single stream" the accountability for allocation decisions becomes obscure. No field can be assured of its fair and continuing proportions.

We urge the continuation of the separation of accounts, with a clear accounting of where the money is being assigned. We also want the public to know how the amounts are determined and allocated.

9. We are greatly concerned with recent fragmentation and isolation of services in alcoholism and drug addiction. We attribute this trend, with its proliferation of agencies and administrative personnel and lack of treatment progress, to be the result of inadequate and poor long-range planning. The focus must return to treatment delivery services. We recommend that these can be improved when they are integrated with the community mental health system and programs and with more traditional treatment programs. This recommends a return to the main stream of mental health treatment services.

10. Recent legislative proposals aimed at correcting commitment defects in the 1966 Act suffer from their own serious defects. Legal attempts which narrowly define "severe mental illness" solely in terms of "clear and immediate danger to self or others" make it impossible to consider other equally destructive, if less dramatic, emotional and mental dangers as cause for commitment.

While we encourage voluntary hospital admission alone as the ultimate aim, society still needs means to commit certain of the mentally ill who cannot be treated otherwise.

The Pennsylvania Psychiatric Society will continue to cooperate in seeking an acceptable solution, but a fresh approach will be needed if last year's experience is considered.

Further data, information, elaboration or discussion is available from the Society for those who may wish it.

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Review of candidal vaginitis— use of candicidin in its treatment

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VAGINITIS is one of the more frequent problems facing the practicing gynecologist in his day-to-day work. Among the primary organisms most frequently involved are *Candida albicans, Trichomonas vaginalis, Hemophilus vaginalis (Corynebacterium vaginale),* and various other bacteria (e.g., *Streptococci* and *Escherichia coli*).

In the past decade, *Candida albicans* has been regarded in many gynecologic circles as the most common cause, accounting, as it does, for up to 60 percent of all cases of vaginitis, either alone or in combination with *Trichomonas vaginalis*.[2,6] This contrasts with the situation fifteen to twenty years ago when most workers found *Trichomonas vaginalis* to be responsible for 60-70 percent of all cases.

The reasons for this increase or relative increase are probably based on several factors, such as the increased use of broad-spectrum antibiotics, adrenocortical steroids, and oral contraceptives, in addition to "unmasking" due to more effective treatment of *Trichomonas vaginalis.* Broad-spectrum antibiotics probably act by altering the normal bacterial flora, allowing overgrowth of candida species.[11] Steroids presumably mediate their effect through changes in cell carbohydrate, and oral contraceptives could act in a similar manner. Some doubt has recently been cast on the "pill" as a significant factor in the etiology of candidiasis. However, if we accept the possibility of the male acting as a carrier of the organism, increased use of the oral contraceptive, as it lessens the need for the use of condoms or other means of contraception, could be important, especially in communities where multiple coital partners are accepted. Recent work has, indeed, shown that spermicidal foams and creams may exert a protective effect against a number of possible vaginal pathogens, including candida.[12]

Vaginitis due to candida presents a vulvar irritation which may be intense, associated with a vaginal discharge, which typically is white and cheese-like, although it may be of any character (Fig. 1). Dyspareunia is very common, and frequency and dysuria are often noted.[9,10] The reason for these symptoms is presumably the involvement of the vulvar area and introitus, although candida has been cultured from the urethra and bladder of women with vaginitis. Genitourinary symptoms, however, rarely require treatment beyond the local therapy for the vulvovaginitis. On clinical examination the vulva may be red, swollen, and excoriated; and vaginal examination usually reveals some degree of erythema, leukorrhea, and sometimes adherent thrush-like plaques (Fig. 1).

The pH of candidal leukorrheal secretion tends towards 5.0 as compared to the normal vaginal pH which has been estimated to be in the area of 4.0.[1] Microscopic confirmation is determined by examination of a wet mount for candidal spores and hyphae. This may be accomplished with normal saline or, for greater accuracy, with 10 percent solution of potassium hydroxide, which renders their features more easily identifiable from other cellular debris and white blood cells. Confirmation by culture can also easily be obtained by use of several media, the most commonly used being Nickerson's medium, on which brown-black colonies appear after incubation for forty-eight to ninety-six hours at room temperature[1] (Fig. 2).

Whereas diagnosis of vaginal candidiasis is relatively straightforward, apparent clinical and micro-

Figure 1.

Figure 2. Nickerson culture medium, c. albicans colonies are brownish-black. (Reproduced by permission of American Family Physician.)

biologic cure after therapy is often compounded by re-emergence of symptoms, especially at the time of the subsequent menses. Candidal reinfection by similar organisms from the patient's own intestinal tract may be the cause of this; but exposure to a male carrier, or recrudescence of quiescent infection of Skene's glands or the endocervical glands is also a possibility. The predominance of recurrence of symptoms at the time of the next menses is probably connected with changes in vaginal pH at that time.

Treatment of vaginal candidiasis over the years has been by a variety of local agents of which recently the most specific have been the topical antifungal antibiotics. Older remedies such as gentian violet are still favored under certain resistant conditions.

Materials and Methods

The present study was designed to demonstrate the efficacy of candicidin ointment (Vanobid® ointment, Merrell-National Labs.). It contains 0.6 mg of candicidin activity in each gram of petrolatum base ointment. Previous studies have reported 80-100 percent cure rates in patients afflicted with candidal vaginitis.[4,5]

Candicidin is a fungistatic and fungicidal antibiotic derived from a soil organism similar to *Streptomyces griseus*, and is a vague relative of nystatin. Its activity was first noted in 1948; and when purified, the active antibiotic was found to have a high degree of "in vitro" activity against various fungi including several species of candida. Its first clinical application in vaginal candidiasis was in 1954.[3] However, it was not generally available until 1964. The drug is not significantly absorbed either orally or topically,[7] and the incidence of side effects and adverse reactions is very low. Occasional slight vulvar irritation has been reported following vaginal application.

Sixty patients from the investigator's practice were studied. All presented with clinical symptoms and signs of vaginitis but were otherwise healthy. No diabetic or menopausal patients were admitted to the study. Likewise, first trimester pregnant patients, those requiring antibiotics concurrently, and those with obvious hormonal unbalance, or those who had been treated within one week for vaginitis of any origin were excluded. Diagnosis was based on history and clinical examination supported by microscopic examination of the vaginal secretions. For the purposes of assessing clinical response, a numerical rating from 0-3 was given for symptoms of discharge, pruritus, and burning—1 corresponding to mild, 2 to moderate, and 3 to severe. Erythema, edema, cervicitis, and leukorrhea were similarly rated on clinical examination. Confirmation of the clinical and microscopic diagnosis was by culture of the secretions on Nickerson's medium; and without positive culture, no patient was continued in the study. Infection by *Trichomonas vaginalis* was eliminated by light microscopy and culture of the secretions on Simplified Trypticase Serum medium. Any patient with evidence of Trichomonal infection or symptomatology or possible history of exposure to gonococcal infection was excluded.

Each patient was instructed to insert one applicatorful (5 gm) of candicidin ointment high in the vagina twice daily for fourteen days, inclusive of days of menses if it occurred during the course of treat-

TABLE I
Pretreatment Evaluation of Symptoms and Physical Findings

Symptoms and Physical Findings	Distribution according to Scores*			
	0	1	2	3
Discharge	1 (1.8%)	2 (3.6%)	28 (50.9%)	24 (43.6%)
Pruritus	14 (25.4%)	3 (5.4%)	18 (36.3%)	20 (39.3%)
Burning	22 (40.0%)	2 (3.6%)	20 (36.3%)	11 (20.0%)
Erythema	18 (32.7%)	12 (21.8%)	21 (38.1%)	4 (7.2%)
Edema	17 (30.9%)	17 (30.9%)	20 (36.3%)	1 (1.8%)
Cervicitis	54 (98.2%)	0	1 (1.8%)	0
Leukorrhea	0	0	12 (21.8%)	43 (78.2%)

* 0 = none 1 = mild 2 = moderate 3 = severe

TABLE II
Results of Treatment

Treatment Period	No. Patients	Results* Cures +	Failures
1 course (14 days)	52	48 (94.2%)	4
2 courses (28 days)	3	1 (33.0%)	2
TOTAL	55	49 (89.9%)	6
Oral contraceptives used	17	15 (88.0%)	2

*Microbiologic and clinical results 30 days after the last course of treatment.

+ Microbiologic cure = negative culture results.
Clinical cure = no signs or symptoms present.

ment. Abstinence from intercourse or the husband's use of a condom was advised. Between three and five days after treatment, the patient was reassessed according to the initial clinical and laboratory parameters. In addition, the dates of onset of relief and complete relief were noted, if applicable. If candida was still present, a second fourteen-day course of treatment was instituted. Final evaluation was performed twenty-eight to thirty-five days after the end of therapy, when examinations and cultures were repeated. Microbiologic cure implied completely negative culture results. Clinical outcome was assessed as complete cure when no symptoms or signs were present, in contrast to ratings of partial cure or failure. By partial cure our criteria allowed for residual leukorrhea, but no other symptoms or signs.

Results

Of the sixty patients who entered the study, five were rejected for final analysis. One failed to return for follow-up, three did not have positive initial culture for Candida, and one was entered into the study twice several weeks apart; the second of these case reports was discarded. A pretreatment symptom/severity distribution table is shown (Table I).

As may be seen, discharge and pruritus were the most frequent symptoms. As regards physical signs, leukorrhea was by far the most prominently reported, whereas cervicitis was found in only one patient. Seventeen of the women were concurrently using oral contraceptives, and five patients had a previous history of vaginitis of varying severity. No pregnant patients were included.

Apart from two patients (one of whom was a cure and the other a failure), all the women reported to have used the medication regularly. It was decided to include the two "defaulters" in the analysis. Three patients required a second fourteen-day course of Vanobid after failure of the first course. Nine women menstruated during the course of therapy, but continued application of the medication.

The fifty-five patients whose records were analyzed ranged in age from eighteen to forty-seven years, with an average age of twenty-nine years. Forty-one of the women reported the onset of symptoms within the week before presentation. Fifty-two women had one course of treatment, and of those—forty-eight (94.2 percent) were cures at the time of both the initial and thirty-day follow-up visits. Three women had two courses of treatment, and of these, one was cured. Overall, out of fifty-five patients, forty-nine (89.9 percent) were cured and remained so for the thirty-day follow-up period of observation. Concurrent use of oral contraceptives did not appear to influence cure rate (Table II).

Symptomatic relief was likewise impressive, onset being noted in the vast majority within twenty-four to forty-eight hours. The mean time to complete relief was 2.7 days with a range from one to six days. This confirms previous observations.[8] No side effects were noted in any patient on the treatment.

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Summary

The present study confirms previous findings of high cure rate in vaginal candidiasis with the use of candicidin. Most previously published work has documented the use of vaginal tablets, although ointment base has also been used. In this present study, prompt symptomatic relief was recorded; and an overall cure rate of 89.9 percent was achieved with one or two courses. Candicidin ointment would appear to be an effective agent for the treatment of mycotic vaginitis, with a very low incidence of side effects or sensitivity reactions. □

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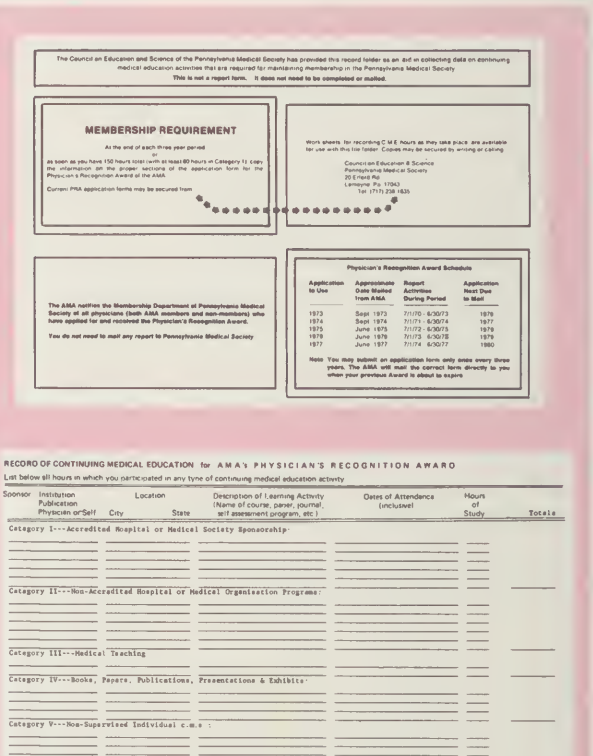

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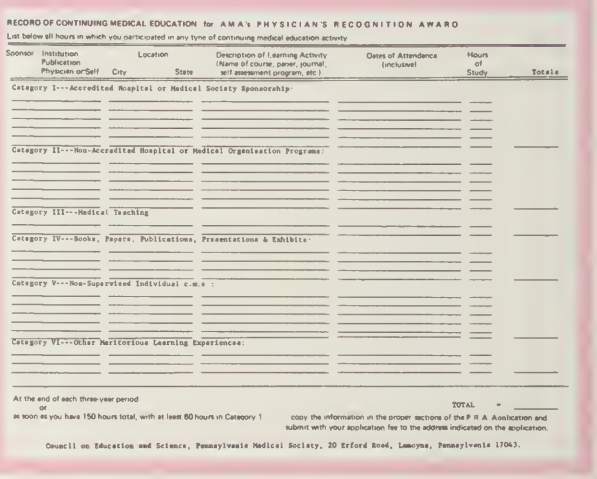

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Society efforts successful!

New Pennsylvania immunization regulations outlined

The Society's three-bill immunization package was completed on September 19, 1974, when Governor Milton J. Shapp signed House Bill 1365 into law. The final law, Act 210 of 1974, exempts physicians and nurses from certain liability when participating in a mass immunization project approved by the Pennsylvania Department of Health.

Mass immunization projects, long a public relations mainstay of county medical societies, came to a halt in 1966 when law suits were filed over the mass polio immunization projects. Since then, physicians and county medical societies generally have avoided mass immunization programs. Legislation designed to provide relief invariably fell victim in the legislature to plaintiffs' attorneys.

However, when the U.S. Public Health Service recommended elimination of routine vaccination for smallpox in 1971, the Society planned and supported new immunization legislation. The three-bill package combined immunity (HB 1365), with an amendment to the school code requiring immunizations for entrance to school (HB 1364) as determined by the secretary of health through the Advisory Health Board (HB 1363). The effort was successful. Acts 66 and 67 were signed by the governor April 11, 1974. Act 210 completed the package.

Act 66 places immunization policy where it belongs—with the Department of Health and the Advisory Health Board. The law is short and states:

> "The Advisory Health Board shall make and from time to time revise a list of such communicable diseases against which children shall be required to be immunized as a condition of attendance at any public, private, or parochial school including any kindergarten in the Commonwealth. Such list shall be promulgated by the Secretary of Health along with such rules and regulations as may be necessary to ensure that such immunization be timely, effective, and properly verified."

Act 67, amending the Public School Code, requires school officials to implement the rules of the secretary of health, as follows:

> "(a) It shall be the duty of all school directors, superintendents, principals, or other persons in charge of any public, private, parochial, or other school including kindergarten, to ascertain that every child, prior to admission to school for the first time, has been immunized, as the Secretary of Health may direct, against such diseases as shall appear on a list to be made and from time to time reviewed by the Advisory Health Board. All certificates of immunization shall be issued in accordance with the rules and regulations promulgated by the secretary of health with the sanction and advice of the Advisory Health Board."

There is a provision for waiver in those instances where immunization is contraindicated by a physician. There is also a waiver for religious grounds.

Passage of the final bill (House Bill 1365) came after agreement by a House Senate Conference Committee. It states:

> "Whenever the secretary of health, or a physician duly licensed in the Commonwealth designated by him, shall approve, in writing, a mass immunization project to be administered in any part of the Commonwealth in cooperation with an official or voluntary medical or health agency, any physician who does not receive remuneration for his services in the project, and any registered nurse, or licensed practical nurse who shall participate in such project and who shall be licensed to practice in the Commonwealth of Pennsylvania shall not be liable to any person for illness, reaction, or adverse effect arising from or out of the use of any drug or vaccine in such project by such physician or such nurse. Neither the secretary of health nor his designate shall approve any such project unless he finds that the project conforms to good medical and public health practice."

The Act, which became effective immediately, does not exempt physicians, registered nurses, or licensed practical nurses from possible suit for gross negligence; nor does it exempt any drug manufacturer from liability for any drug or vaccine used in such a project.

Implementation of the laws occurred August 3, 1974, with publication in the *Pennsylvania Bulletin* of rules and regulations for the immunization of school children as follows:

> "Immunization is required as a condition of attendance at any public, private, or parochial school including any kindergarten against the following communicable diseases: diphtheria, tetanus, type I, type II, and type III, poliomyelitis, measles, and rubella (German measles). It shall be the duty of all school directors, superintendents, principals, or other persons in charge of any public, parochial, or other school including kindergarten to ensure that every child, prior to admission to school for the first time has been immunized or has a program to promptly acquire immunization against the above-mentioned communicable diseases."

Later the department clarified its definition of immunization against diphtheria saying it ". . . shall consist of three or more properly spaced doses of diphtheria toxoid. These immunizations may be accomplished by administering diphtheria toxoid, diphtheria and tetanus toxoids, or diphtheria toxoids and pertussis vaccines."

Immunization against tetanus is revised to read: "Three or more properly spaced doses of tetanus toxoid. These immunizations may be

accomplished by administering tetanus toxoid, diphtheria and tetanus toxoid, or diphtheria and tetanus toxoids and pertussis vaccine."

Immunization against poliomyelitis is specified as: "Three or more properly spaced doses of trivalent oral polio vaccine."

Immunization against measles was defined as: "A single dose of live attenuated measles vaccine or a history of a medically confirmed case of measles."

Finally, immunization against rubella (German measles) is defined as: "A single dose of live attenuated rubella vaccine."

As soon as the regulations became public, the State Society issued a widely used press release to inform the public of the new requirements, and Society-sponsored radio broadcasts during October—immunization action month—emphasized the importance of protecting children against the specified diseases. County medical societies once again are sponsoring mass immunization programs as public service projects. Health department spokesman Robert E. Longenecker said the department currently is assisting some school districts in efforts to conform with the new laws, but does not at this time have plans for mass immunization projects.

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Pulmonary embolism—the team approach

ROBERT G. TROUT, M.D.
Philadelphia

The diagnosis of pulmonary embolism, regardless of the extent or severity, very rarely is a clear-cut entity on clinical grounds. It has been a diagnostic enigma since its first clear description by Helie in 1837.[1] While more sophisticated studies are of great help, and the definitive study of pulmonary arteriography establishes the diagnosis, there are sometimes delays in recognition and, therefore, delays in the establishment of an appropriate therapeutic program. In 1963, Smith, Dammin, and Dexter[2] conducted arteriographic studies on 307 autopsies. They found that forty-seven patients died of pulmonary embolism and that the diagnosis had been suspected in less than one-half of the subjects. Morrell and Dunhill[3] in 1968 revealed that in 236 cases 51 percent had pulmonary embolization. In 37 (or 15 percent) of these autopsied patients, death was entirely attributable to the embolus, and these deaths were potentially preventable.

In a series of some ninety patients (Fig. 1) Israel and Goldstein[4] found that symptoms and signs varied greatly but that chest pain was noted in approximately 70 percent, with dyspnea in 45 percent and hemoptysis only in 30 percent. In this same series, variable electrocardiographic changes were noted in approximately one-half of the patients. Compounding the difficulty in diagnosis is the frequent presence of co-existing serious disease. This would include the presence of widespread malignancy, advanced cardiovascular disease with congestive failure, and cerebrovascular disease. In this regard the greatest clinical mandate to physicians is to distinguish promptly between a massive pulmonary embolus and other conditions that might present a similar clinical

PATIENTS WITH PULMONARY EMBOLI ISRAEL + GOLDSTEIN 1957—90 CASES

	%
● PAIN	72
● DYSPNEA	46
● HEMOPTYSIS	29
● FEVER	80
● TACHYCARDIA	60
● PLEURAL RUB	25
● PHLEBITIS	64

Fig. 1. Symptoms of pulmonary embolism.

Fig. 2. Case 2. Lung scan in suspected case of pulmonary embolus reveals total lack of perfusion of the right lung. Working diagnosis was pulmonary embolus.

picture. The two most important possibilities are acute coronary occlusion or dissecting aneurysm of the thoracic aorta. Obviously, surgery intended to remedy the catastrophic sequella of a major pulmonary embolus would be uniformly fatal in a case of severe coronary occlusion or a dissecting aneurysm. By the same token, the use of anticoagulation in the face of dissecting aneurysm would also be contraindicated. Hence prompt and accurate dignosis is essential.

Formerly, gastrointestinal bleeding problems were handled by a single discipline. Today, in enlightened institutions a multiple discipline approach is utilized, and the recovery rate with conservative or surgical management has increased. The mortality and morbidity rates have markedly decreased, proving the efficacy of the team approach. A multidiscipline approach is mandatory in this day and age in the management of the patient suspected of having sustained a pulmonary embolus from any source and of any degree of severity. The team should include the primary physician and should have expertise in the fields of cardiology and clinical laboratory techniques. Skill in radioisotopic procedures and interpretation with radiographic support including arteriographic capabilities is also essential. The surgical discipline is also highly desirable, even though no surgical therapy is contemplated at the outset.

Confronted with a patient where pulmonary embolism is even remotely suspected, the following program is suggested. An immediate chest roentgenogram and a baseline electrocardiogram should be obtained with serial tracings on an hourly basis in the severely ill patient. Laboratory studies, including the usual enzymes and arterial blood gas analyses, are essential. The use of an isotopic scintillation scan of the lungs is also indicated and can usually be obtained without major risk to the patient. Pulmonary arteriography is the final arbiter of all questionable cases, and where available it should be employed freely as the risk involved is far outweighed by the information obtained even in the critically ill patient. The use of peripheral venography is also helpful where the source of the embolus is in doubt and is valuable in planning therapy, particularly when the possibility of venous interruption is being considered. The surgical discipline may be useful in the establishment of monitoring systems for central venous pressures and where expertise is unavailable for radiographic aid in introducing catheters.

The medical management of pulmonary embolus has been well outlined by previous authors. Basically it is predicated upon the prevention of propagation of thrombotic material within the lungs or in the systematic venous channels. It consists primarily of heparinization and the possible use of thrombolytic agents such as streptokinase or urokinase. Special note should be made of the use of heparin in the acute phase. It should be a substantial dose within the range of 10,000 to 15,000 units intravenously, and should be administered promptly, then maintaining adequate levels of anticoagulation.

Once the diagnosis is established and anticoagulation therapy instituted, surgical consultation is useful in venous interruption at the caval,

Fig. 3. Pulmonary arteriogram Case 2, demonstrating complete and selective compressive obstruction of right pulmonary artery.

Fig. 4. Postoperative pulmonary arteriogram of Case 2 with complete restoration of normal flow to the right lung.

femoral, or iliac areas where indicated. In the case of massive pulmonary embolus with a degenerating clinical status, a decision regarding the use of pulmonary embolectomy must be a team decision and must be made promptly. Early decision is also important in the catastrophically ill patient if the patient must be transferred to a center where cardiopulmonary bypass surgery can be done. This decision was made in three clinical cases in our recent experience, and successful pulmonary embolectomy was performed following the transfer of the patient to a more suitable center.

The true need for pulmonary embolectomy represents a very small percentage of all cases seen, and it should be reserved for those patients who are obviously moribund and are deteriorating in the face of adequate conservative management. The following clinical illustrations are offered as guides.

Case Reports

No. 1. A 30-year-old high school coach was admitted with severe chest pain, dyspnea, and tachycardia with pallor and questionable cyanosis. The working diagnosis was myocardial infarction. Electrocardiogram revealed right heart strain and no evidence of infarction. A lung scan was positive. Heparin anticoagulation was started, and the patient was stable for thirty hours when he became hypotensive, and marked ischemic changes appeared on the electrocardiogram. Surgical consultation was obtained, and a pulmonary arteriogram was done. The diagnosis of massive pulmonary embolus was made. With the patient steadily deteriorating, he was transferred to a center where circulatory support was immediately started followed by pulmonary embolectomy and ligation of vena cava. The patient recovered and is at full activity some three years later.

No. 2. A 59-year-old female was admitted with a positive history of severe chest pain, dyspnea, and tachycardia. She was known to have moderately far-advanced arteriosclerotic cardiovascular disease with proven myocardial infarction resulting in congestive heart failure two months prior to admission. The patient was stable without specific management, and the electrocardiogram was equivocal. Chest x-ray revealed a large shadow in the area of ascending aorta in the mediastinum. A lung scan (Fig. 2) was done which revealed total lack of perfusion of the right lung. The diagnosis of pulmonary embolism to the right lung was made. Heparinization was carried out and because of her previous history, Lasix® (Hoechst Pharmaceuticals) and Digoxin® (Lederle Laboratories) were continued. Because of the chest roentgenogram and the suspected ascending arch aneurysm of the aorta, the patient was transferred to a center where both pulmonary arteriography and systemic aortography were available. These studies revealed complete occlusion of the right pulmonary artery (Fig. 3). Instead of a pulmonary embolus, a large and expanding aortic aneurysm of the ascending arch of the aorta with selective compressive obstruction of the right pulmonary artery was diagnosed by the radiologist. Heparinization was immediately discontinued, and operation was performed with resection of the aneurysm and grafting. Postoperative pulmonary arteriography (Fig. 4) was completely normal. In this case the radiological input was life-saving.

No. 3. A 28-year-old male with a history of previous pulmonary embolus who had been on long term anticoagulants for four months was admitted with severe chest pain, tachycardia, and mild dyspnea two weeks following the cessation of his long term anticoagulation. A prompt pulmonary arteriogram was done, and the suspected diagnosis of recurrent pulmonary embolus was confirmed. Anticoagulation was immediately restarted using heparin. A venogram was done the following day, and massive clots were noted in the iliac vein. The inferior vena cava was promptly clipped (Fig. 5), and the patient was placed on long-term anticoagulation. No further episodes of embolization have occurred.

Dr. Trout is chief of the department of thoracic and cardiovascular surgery at the Presbyterian-University of Pennsylvania Medical Center, Philadelphia.

Fig. 5. Postoperative venogram in Case 3 demonstrating large quantities of clot in left iliac vein just distal to confluence of iliac veins into inferior vena cava and flow through clip on inferior vena cava.

Summary

A case has been made for a multidisciplined approach in all cases of suspected pulmonary embolus. There are substantial problems in the clinical recognition of this enigmatic entity. Therefore, all available diagnostic and therapeutic expertise is required. Selected cases have been used for illustration and to support the thesis of a realistic team approach. □

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Medical treatment of thrombophlebitis and pulmonary embolization

NORMAN J. SKVERSKY, M.D.
Philadelphia

In treating thrombophlebitis and preventing thromboembolic phenomena, the two most widely used agents are heparin and the coumarin derivatives. Discussion of the merits and demerits of both groups is based on my use of heparin since 1943 and the coumarin drugs since shortly thereafter.

Heparin

The anticoagulant action of heparin, attributed largely to its highly negative charge, depends upon its inhibition of certain interactions involved in thromboplastin production, in thrombin formation, and in thrombin deposition. In appropriate doses heparin also prevents platelet agglutination and potentiates the fibrinolytic system. Its main biologic activity is its ability to inhibit the clotting of blood or plasma. The toxicity of heparin is very low, and even maintaining the blood in an incoagulable state does not lead to spontaneous hemorrhage unless some sort of injury is superimposed or a lesion is present subject to bleeding such as polyp, tumor, or ulcer).

A most important safety factor in the use of heparin in pregnant females comes about because the drug does not pass the placental barrier and does not appear in breast milk.

The anticoagulant action is proportional to the dose. Although it may vary from patient to patient, in any one individual it remains remarkably constant when given intravenously. This, however, does not apply when given subcutaneously because of wide variation in rate of absorption and because of the cumulative effect often observed. When given intravenously, the anticoagulant effect as measured by the Lee-White time is usually about two hours, but the antithrombotic effect may last from four to six hours because of the negative electrical charge which makes the platelets and red cells repel each other.

In addition to its lack of toxicity and its few allergic responses, heparin does not significantly interfere with the extravascular deposition of fibrin and, therefore, does not retard wound healing. Another advantage is the ease with which the anticoagulant effect of heparin can be neutralized; and in most instances protamine is used. Whole blood and plasma, although of value in replacing blood or plasma volume, are not specific antidotes against heparin.

Coumarin Type Drugs

The coumarin type drugs derive their anticoagulant effect from interfering with the normal synthesis of Factors II, VII, IX, and X. The hypocoagulable state produced results in the suppression of fibrin clotting throughout the vascular system. Some evidence exists that platelet adhesiveness and platelet thrombus formation is decreased by administration of the oral anticoagulants. Coumarin type drugs do pass into mother's milk, and there are many drugs which when taken at the same time the oral anticoagulant is given either depress or increase the prothrombin time so that regulation of dosage for maximum therapeutic effect and prevention of bleeding is very difficult. Neutralization of the anticoagulant effects of coumarin type drugs may take many hours or days when using preparations of vitamin K, whereas using whole blood or plasma works very rapidly.

Other Agents

Fibrinolytic agents have a very definite place in medical management of thrombophlebitis and pulmonary embolization. Streptokinase activates circulating plasminogen to produce plasmin, a proteolytic enzyme which cleaves the fibrin molecule into small-sized soluble fragments. Under normal circumstances, thrombin is the factor which initiates the conversion of plasminogen to plasmin. Thus the circumstance that initiates the formation of a clot also initiates its lysis. However, after streptokinase administration, there is a predisposition to thrombosis, and heparin should be administered.

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Urokinase has been undergoing, therapeutic trails for many years, but is not generally available. It also activates plasminogen and, in a national urokinase study, was proved superior to heparin, but the problem of rethrombosis after discontinuation of the drug was also noted. Again heparin must be instituted.

The proposed advantages of treatment of venous thrombosis by lysis therapy over anticoagulant therapy are that if instituted soon enough, the valves remain unscarred and competent, avoiding the postphlebitic syndrome. This is open to question. Also the total course of therapy is usually much shorter according to many investigators, but in my experience the main key to success is early and prolonged therapy. In uncomplicated deep vein thrombophlebitis, I use heparin I.V. for a minimum of ten days and then switch to a q-12-hour dosage subcutaneously for another two to three weeks. If pulmonary embolization has occurred, I prefer to keep the patient on heparin for a minimum of three weeks intravenously followed by an additional three to six months of heparin subcutaneously. In most instances I have abandoned the use of oral anticoagulants since subcutaneous administration of heparin is relatively simple.

The dextrans, and particularly low molecular dextran, have been used for many years with conflicting reports. Dextran 40 does not achieve its effect by blocking fibrinogen-fibrin conversion, but instead by simultaneously inhibiting two other mechanisms essential to thrombus formation—namely vascular stasis and platelet adhesiveness. To prevent thrombophlebitis, particularly postoperative thrombophlebitis, the drug should be given preoperatively and continued postoperatively. I use low molecular dextran in preference to the lytic agents when heparin is contraindicated.

Conclusion

In my experience, heparin is most effective in the vast majority of cases of deep vein thrombophlebitis and pulmonary embolization. I prefer using the intravenous route at four-hour intervals; although in the aged, the hypertensive, and during menstral periods I usually give it every six hours. Dosage should be varied depending upon the weight of the patient and the result of laboratory tests (including the Lee-White time and partial thromboplastin time or the activated partial thromboplastin time). I like to check the level one half to one hour after an I.V. dose and immediately before the next dosage on one or two occasions. If given subcutaneously, I do the laboratory studies three to four hours after a dose and just before the next dosage. The time of testing may vary, depending upon the dose used since the anticoagulant effect is proportional to the dosage.

The urine should be checked daily for microscopic hematuria and a hemoglobin and hematocrit performed twice a week. The main complication of heparin administration is hemorrhage, particularly in the aged, hypertensive, and in patients with malignancy.

One further word of caution: If possible, avoid concomitant administration of intramuscular medication in patients on heparin. If this is unavoidable because of infections requiring such therapy, be sure to space the intervals of administration properly and maintain prolonged pressure at the sites of injection. The judicious use of local ice packs is also advisable. □

Minimizing thrombophlebitis and pulmonary embolism risk in orthopaedic surgery

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In light of information provided by the increasingly sophisticated detection devices for thrombophlebitis, it has become quite evident that thrombophlebitis and thromboembolic phenomenon may be found in over half of the postoperative cases in patients being operated on for lower extremity difficulty.[2,3,9,10,15] A clinical manifestation of this condition has been noted by Harris, Saltzman, and DeSanctis in 39 percent of patients undergoing elective hip surgery.[8]

The pathologic correlation between thrombophlebitis and pulmonary embolus has not yet been fully clarified. The fatal outcome of many patients with pulmonary embolus is well known, however, and it behooves us as physicians and surgeons to attempt to prevent thrombophlebitis by whatever means possible in order to avoid the dreaded complication of pulmonary embolism. While several studies in the recent past have lauded the merits of anticoagulant drugs, such as Coumadin® (Endo Laboratories, Inc.) low molecular weight dextran, aspirin, and Persantin® (Geigy Pharmaceuticals), in general heparin has been found to be the most reliable anticoagulant drug.[4,11,12,14,16] It acts rapidly, clears the system rapidly, is effective as an anticoagulant

TABLE I

Patient Study

83 total patients
55 female—28 male
(age range 24-78, average 55 years)
100 major operations
95 total hip replacements
5 total knee replacements
Follow-up one to three years

in reducing new clot formation, and is easily administered. Its one difficulty lies in the inability to accurately measure effectiveness as an anticoagulant by any commonly performed laboratory study.[1]

The dispute over whether high or low doses of heparin should be administered and whether they should be administered preoperatively, intraoperatively, or postoperatively, and for what duration they should be administered postoperatively is still unsettled.[11] Our series of 100 cases should add some significant information to the body of the data that is being collected on the use of heparin as a prophylactic anticoagulant. We chose to use low dose heparin and to give it for a long period of time (six weeks) postoperatively.

Materials and Methods

Our series consists of 100 major reconstructive procedures performed on the lower extremities in an elective fashion. These operations include ninety-five total hip replacements and five total knee replacements. Eighty-three patients were operated upon, fifty-five female and twenty-eight male. Their ages ranged from twenty-four to seventy-eight with an average of fifty-five years. All patients have been followed for one to three years.

The program of prophylaxis against thrombotic and thromboembolic phenomenon began preoperatively with a routine examination of the prothrombin time, platelets, and Lee-White clotting time. No patients were found to have significantly abnormal studies. No heparin was given preoperatively or intraoperatively. Patients were placed in slight Trendelenburg position on the operating table to promote venous drainage of the lower extremities.

Postoperatively, several things were done to prevent thrombophlebitis. (1) The legs of the patients were compressed in ace bandages or antiembolic stockings; (2) the foot of the bed was elevated to enhance venous drainage; (3) active exercises, in terms of dorsiflexion and plantarflexion of the foot and ankle, and flexion and extension of the knees were started within twelve hours on both the operative and nonoperative limb. (4) patients were ambulated early, bearing as much weight as could be tolerated on the affected limb. This usually resulted in ambulation of both total hip and total knee patients by seven days postoperatively.

Intravenous heparin was begun twenty-four hours after the suction drain was removed from the wound, or forty-eight hours postoperatively. 2,000 to 3,000 units of aqueous heparin were given intravenously every eight hours. This program continued until the patients were ready for discharge in two to three weeks. At that time, the patients were taught to give themselves heparin subcutaneously, and their therapy was continued at home with 3,000 units of aqueous heparin being given every twelve hours subcutaneously for three additional weeks. Examination for thrombophlebitis was performed on a daily basis. This consisted of examination of the calves for tenderness or increased warmth or girth and examination for a positive Homan's sign. Only in cases where pulmonary embolus was suspected were diagnostic studies, such as pulmonary scans and pulmonary angiograms performed.

TABLE II

Prophylactic Treatment Against Thrombophlebitis and Pulmonary Embolism

I. Preoperative
(A) CBC, Prothrombin time, platelets, Lee-White clotting time
(B) Rule out contraindications such as GI bleeding or intracranial hemorrhage

II. Intraoperative
Slight Trendelenburg position on the operating table

III. Postoperative
(A) Compression of lower extremities in ace bandages or antiembolic stockings
(B) Elevation of foot of bed
(C) Active exercises within 12 hours on both lower extremities
(D) Early ambulation, weight bearing as tolerated in one week
(E) Heparin therapy (beginning 24 hours after suction drain removal)
1. 2,000 - 3,000 units aqueous heparin intravenous q.8.h. for two to three weeks
2. Subcutaneous heparin 3,000 units q.12.h. for three additional weeks

Results

One hundred operations were performed. Clinical phlebitis was noted in three patients (3 percent). Pulmonary embolus verified by pulmonary scan occured in one patient (1 percent). In three patients (3 percent), excessive bleeding in the wound producing a hematoma was found. In no cases did the hematoma necessitate evacuation or in any way interfere with the normal course of healing of the wound or interfere with the function of the prosthesis. There were no other complications of heparin therapy such as gastrointestinal or urinary tract bleeding or soft tissue hemorrhage.

Discussion

Patients on heparin were checked with Lee-White clotting times several times a week. It was found that in some cases the clotting times were two to three times normal on 2,000 units q.8.h.; and in other cases, such as the one case which developed a pulmonary embolus, 5,000 units of aqueous heparin given every six hours did not increase the clotting time from the normal value. Clotting times, therefore, were utilized to insure that an overreaction to the low dose heparin did not occur, but were not

TABLE III

Results of Clinical Study

(A) Clinical phlebitis found in three patients (3%)
(B) Pulmonary embolus (nonfatal) one patient (1%)
(C) Pulmonary embolus (fatal) 0 patients (0%)

Complications:

(A) Mild hematoma three patients (3%)
(B) Gastrointestinal, urinary tract or soft tissue hemorrhage, no patients (0%)

used to titer the dosage. The use of low dose heparin has been reported by Sharnoff et al in 1959[13] and 1970[14] and by Gordon-Smith et al in 1972.[7] None of these studies were effectively controlled, however. It was the opinion of these authors that low dose heparin effectively reduced thrombophlebitis, although no conclusions could be drawn as to the efficacy of subcutaneous heparin in preventing pulmonary embolus. In both of these studies heparin was given preoperatively, intraoperatively, and postoperatively for a short period of time.

Gallus et al[6] in the *New England Journal of Medicine* in March of 1973 reported on a study in which 5,000 units of heparin were given subcutaneously until the patients were mobile. The drug was given again preoperatively, intraoperatively, and postoperatively. The incidence of venous thrombosis was significantly lower in the treated patients, as indicated by labeled fibrinogen scanning studies.

Our study differs from the previous reports in several ways. No preoperative or intraoperative therapy was given. Postoperatively the therapy was started intravenously and continued at a lower level than is usually given (2,000 to 3,000 units every eight hours, as opposed to 5,000 units every eight hours) over a period of two to three weeks and then continued subcutaneously for an additional three weeks. Our results compare quite favorably with other studies utilizing heparin-prophylaxis in low doses and with the series of Harris et al, in which 7 percent[8] of the patients receiving Coumadin therapy developed thromboembolic complications. Our study is in disagreement with that of Evarts and Alfidi[5] who studied twenty-five patients undergoing total hip replacements at the Cleveland Clinic, utilizing preoperative, postoperative, and subcutaneous heparin in 5,000 units every twelve hours for seven to ten days. In their series, deep vein thrombosis developed in 28 percent of the patients as diagnosed by phlebography, and pulmonary embolus developed in 24 percent of the patients. It is to be noted, however, that if routine venography had been done in all of our patients, most assuredly the rate of thrombophlebitis as determined by a positive venogram would have been higher.

However, our rate of nonfatal pulmonary embolus at 1 percent was much lower than that of Evarts and Alfidi. In our series, in addition, it is to be noted that no patient developed thrombophlebitis while on heparin, except for the one patient who was refractory to heparin as indicated by her Lee-White clotting time and who subsequently developed a pulmonary embolus. The other two patients developed signs of thrombophlebitis after six weeks of therapy. Our study would indicate that prolonged use of low dose heparin and ancillary prophylactic techniques is effective in preventing thrombophlebitis and, at least as far as our small sample is concerned, in preventing or reducing the incidence of nonfatal or fatal pulmonary embolus. □

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Home treatment for hemophilia

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This paper was prepared by the Hemophilia Center of Western Pennsylvania. Ms. Gorenc is coordinator of the center, and Dr. Lewis is director. Dr. Lewis is also chairman of the Advisory Committee for Hemophilia of the Pennsylvania Department of Health. This is the third in a series of articles on hemophilia.

TABLE I

Criteria for Selection of Patients for Home Treatment

1. Desire to join the program
2. Severe to moderately severe hemophilia A or B with no demonstratable inhibitor
3. History of six or more hemorrhagic episodes per year requiring treatment
4. Willingness to cooperate closely with the center during training, to follow instructions, and to return for regular check-ups
5. Intellectual and emotional status of the patient and/or a family member which allows acceptance of responsibility and understanding of hazards
6. Suitable age—12 years or above for self-administration
   — 4 years or above for parental administration
7. Sufficient veins visible or palpable on hands or lower arms

Although home treatment for hemophilia is not a new concept, its widespread use has become possible with the ready availability of lyophilized factor concentrates. These have eliminated the necessity for consideration of blood type and frozen storage of plasma or cryoprecipitate. They also offer adequate treatment in a small volume, standardized unitage, and provide material essentially free from allergens. Disadvantages of the lyophilized concentrates are increased danger of transmitting hepatitis and greater cost. The former is due to the very large plasma pools (4,000+ donors) from which these lyophilized fractions are prepared. Although donors are pretested for hepatitis B antigen by radioimmunoassay, the risk has not completely been eliminated. For the severe hemophiliac, the hazard of hepatitis is balanced by the prevention of crippling or the rehabilitation made possible with the use of fractions. Home treatment allows early or preventative therapy thereby averting loss of time and disruption of activities by frequent trips to the hospital, clinic, or emergency room. In addition, it allows the patient to live at a considerable distance from the clinic or doctor and to enjoy traveling without restriction.

TABLE II

Programs for Home Treatment

I. Early Rx: Dose given at first symptom

II. Regular Rx: Dose given on alternate days

Combined I and II: Changing every three months

There are nine Hemophilia Centers in Pennsylvania,* and most of these offer training in home treatment techniques. Before a patient can be accepted into such a program, his diagnosis must be confirmed; and he (and a parent, if he is a child) must be interviewed by the center physician. If he fits the criteria listed in Table I, he can be entered into a series of teaching sessions. If he is a child, one or the other parent usually undertakes responsibility and develops the necessary skills.

Two programs for home treatment are listed in Table II. In early home treatment, the fraction is ad-

* *Lewis, J. H.; Gens, R. D. Hemophilia and the Pennsylvania program. Pennsylvania Medicine, 77:54, 1974.*

ministered immediately upon recognition of the earliest symptoms of hemorrhage. In the case of hemarthrosis, this is usually a feeling of fullness or pain in a joint. Patients on program I are instructed that early hemarthroses, hematomata in nonhazardous areas, external bleeding from deep cuts, hematuria, or epistaxis may be safely treated with a dose calculated to obtain an initial level of 25 percent activity. If necessary the infusion may be repeated in twelve hours. When more serious hemorrhages occur (for instance in the neck, throat, gastrointestinal tract, abdomen, or chest), a double dose (to achieve 50 percent activity) should be given; and the patient should come to the center or hospital emergency room. Following an accident or head injury, even if no bleeding is apparent, the patient should take the double dose and call the physician. Bleeding into a hip joint and hematuria are two types of hemorrhage which may be difficult to control; and in these instances the patient should telephone the center where someone is available to provide therapeutic guidance.

The second program for home treatment is one in which the fraction is administered every other day for hemophilia A and every third day for hemophilia B. The standard (25 percent) dose is used. Regular treatment is indicated for clinically severe cases in which bleeding episodes have occurred at least once a week and for patients on extensive physiotherapy. For patients who have suffered recurrent hemorrhages into the same joint, this treatment often reduces synovitis and halts destructive osteoarthritis. However, this regular treatment program is costly and may result in temporary phlebitis. In many cases alternation of regular and early programs at three month intervals has been shown to be physically and psychologically advantageous.

The first teaching sessions emphasize the importance of choosing a quiet, clean area with a good light for home self-administration. Only the family member who will help or actually do the venepuncture should be present. Mixing and preparation of the fraction are taught as per the manufacturer's instructions. When all the concentrate is dissolved, air is injected and the contents drawn into a syringe through a filter needle to remove microembolic material. The direct intravenous route, via a 23 gauge infusion set, is preferred over drip infusion. The tubing on most infusion sets is about twelve inches long, allowing the needle to be placed in any hand or lower arm vein, while the hub is held between thumb and forefinger. Sites of venepuncture are varied. After allowing the tubing to fill with blood, the syringe is inserted into the hub of the infusion set. Holding the syringe in a vertical position, concentrate is injected slowly (±3 minutes). Applying pressure with his chin on the syringe plunger may help start the infusion for the patient who is alone. At the end of the infusion, care should be taken to allow all of the concentrate, but no air, to enter the vein. The patients are also taught to destroy the used needles and syringes before discarding soiled materials.

Although reactions following infusions are rare, each patient is provided with an antihistamine and instructions for its use. Any adverse reaction must be reported promptly.

Dose calculations are very important and are discussed with the instructor for each new lot of concentrate. Table III lists bottles to be given for each nonmultiple weight in order to achieve the calculated 25 percent level. For weights not listed, multiples should be used, e.g. 150 lbs. = 3 x 50 lbs. Babies weighing less than 30 pounds will be discussed in a later article. The units per bottle vary considerably, and Table III shows two extremes. Obviously one must not waste material to reach an exact level. For instance, if the calculated dose is two and one half bottles, one may alternate between three and two bottles if repeated doses are necessary. Technically it is easier to inject the more concentrated fraction, but it is important to use the products of *all* manufacturers because the materials produced today are barely sufficient for the needs of the country. Thus, each company must be supported by our patronage or real shortages of fractions may develop.

TABLE III

Dose Calculations

Weight in pounds		30	40	50	70	110	130	170	190
Plasma Vol. (ml)		660	880	1100	1540	2420	2860	3740	4180
25% dose - units		165	220	275	387	605	715	935	1045
Bottles	182 u	1	1	2	2	3	4	5	6
	387 u	1	1	1	1	2	2	3	3

Patients are also instructed to keep precise records of each bleeding episode, the treatment results, and time lost from school or work. These records are reviewed during the periodic follow-up visits and the dosage changed if necessary. The records also provide a data base from which the efficacy of the program will be assessed in the future. The periodic visits, which take place about every six months, include a brief medical and orthopedic evaluation and laboratory examination for liver function, hepatitis B Ag/Ab, hematocrit, and inhibitor to factor VIII or IX.

In our state, home treatment is generally paid for through insurance policies. If the insurance does not cover and the patient cannot afford home treatment, assistance is available through the Pennsylvania Hemophilia Program. Patient acceptance of the program has been enthusiastic, and there are now over 200 individuals on home treatment in the state. The following three advantages are impressive: (1) *Medical:* control of pain without narcotics and prevention and/or correction of crippling; (2) *Psychological:* development of independence and self-confidence; and (3) *Financial:* savings on hospital, clinic, and doctor bills—and *most importantly,* full employment of rehabilitated individuals. □

Preservation of human kidneys for transplantation

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PRESERVATION of human cadaver kidneys has become an essential part of kidney transplantation since 1967 when Belzer and associates described a method for short-term isolated perfusion of kidneys using profound hypothermia, a membrane oxygenator, continuous pulsatile perfusion, and a perfusate of cryoprecipitated plasma.[1]

At Hahnemann Medical College and Hospital, basic animal experiments with kidney preservation utilizing the Minnesota Renal Preservation System was completed in 1971 and became clinically functional in January 1972.

The purpose of this paper is to review two years' experience in the kidney preservation laboratory and point out several pertinent observations related to cadaveric kidney preservation and transplantation.

Material and Method

Selection of Donor—From January 1972, to December 1973, sixty-eight cadaver kidneys were received for transplantation by interhospital cooperation in eastern Pennsylvania and the southern New Jersey area. This includes exchanging of donor kidneys between transplantation centers and donation of kidneys from nontransplantation hospitals (Table 1). Once a potential donor is

TABLE I

Total Number of Cadaveric Donor Kidneys Received From January 1972 - December 1973: 68

Kidneys Transplanted: 45	
Hypothermic preservation and transplantation	2
Perfusion (6 - 25 hours) and transplantation	43 (3*)
Kidneys Discarded: 23	
(1) Irreparable injury to donor kidneys	7
(2) Gross anatomical defects including congenital and acquired	5
(3) Poor perfusion parameters	5
(4) Bacterial or viral infection found during or after donor nephrectomy	3
(5) Miscellaneous reasons	3

* Three kidneys were transplanted at other hospitals.

TABLE II

Cadaver Kidney Donor General Criteria of Acceptability

1) Age: up to 65 years old
2) No prolonged period of hypotension
3) Functional kidneys
4) No systemic infection
5) No malignant tumor (primary brain tumors which do not metastasize outside the skull are acceptable)

identified and consent of the donor's nearest kin is obtained, necessary laboratory studies are carried out and proper donor support measures are instituted by the donor's primary physician with the technical assistance of a member of the transplant team (Table II).

Irreversible brain damage secondary to head trauma and spontaneous cerebral hemorrhage were the most common causes of donors' deaths in our series.

The patients with irreversible brain damage following craniotomy, open heart surgery, or myocardial damage can also be considered as kidney donors. Age distribution and blood type of donors are listed in Tables III and IV.

Donor Nephrectomy—Approximately 50 percent of the donor nephrectomies were performed by Hahnemann transplantation surgeons. The donor was transported to the operating room, and an adequate amount of intravenous fluid was administered to maintain blood pressure and urine output. Mannitol® (Abbott Laboratories) and Lasix® (Hoechst Pharmaceuticals, Inc.) were also given routinely before donor nephrectomy. Intravenous heparin 10,000 units was given before cross-clamping the abdominal aorta. If death occurred in the ward, heparin was given via CVP catheter or by intracardiac injection followed by the initiation of cardiac massage. Then the donor was brought to the operating room as soon as possible to minimize warm ischemia time.

Care was taken not to injure those structures which are vital to transplantation, e.g. renal artery, vein, capsule, and ureter with accompanying nutrient vessels. It is our policy to remove both kidneys with a section of aorta and inferior vena cava, regardless of the number of renal arteries or veins present, in order to prevent inadvertent division or ligation of accessory vessels (Fig. 1).

Kidneys from pediatric age donors were removed en bloc with abdominal aorta so that the kidneys could be perfused through the aorta. After removal, the kidneys were immediately immersed in iced saline and perfused with ice cold Ringer's lactate 1,000 cc with 100 mg of procaine sulfate and 5,000 units of heparin. Recently, we have been using C_3 solution instead of lactated Ringer's solution.[2] The kidneys were then packed with slushed ice saline in a plastic jar within two sterile plastic bags which were placed in ice cubes in a styrofoam container. This simple iced saline pack is more than adequate to transport kidneys back to our organ preservation laboratory. Upon arrival of the donor kidneys in the laboratory, the kidneys were placed in the perfusion cassette under sterile conditions.

Preservation Method—The kidneys were perfused from six to twenty-five hours in the Waters MOX-100 organ preservation apparatus (Figs. 1 and 2).

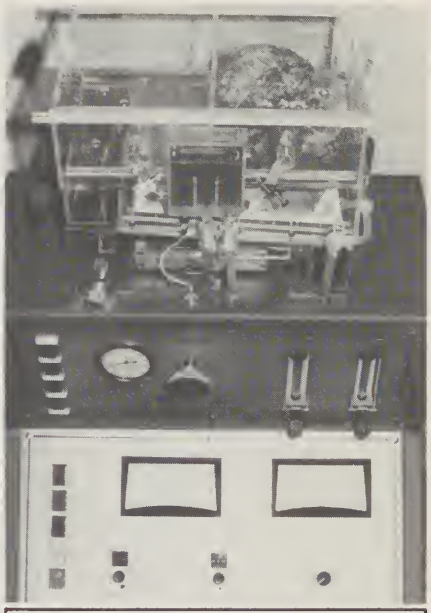

Fig. 1: Console Medule, Minnesota Preservation System

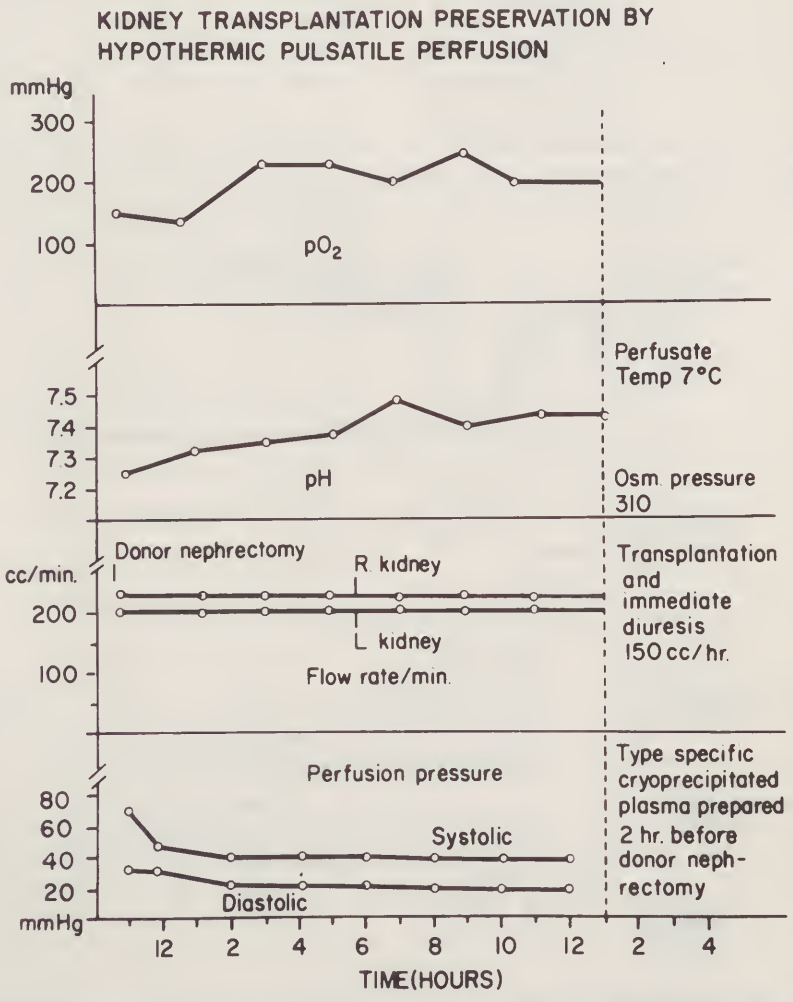

Fig. 2: Perfusion Parameters, human cadaver kidney allografts, C-18

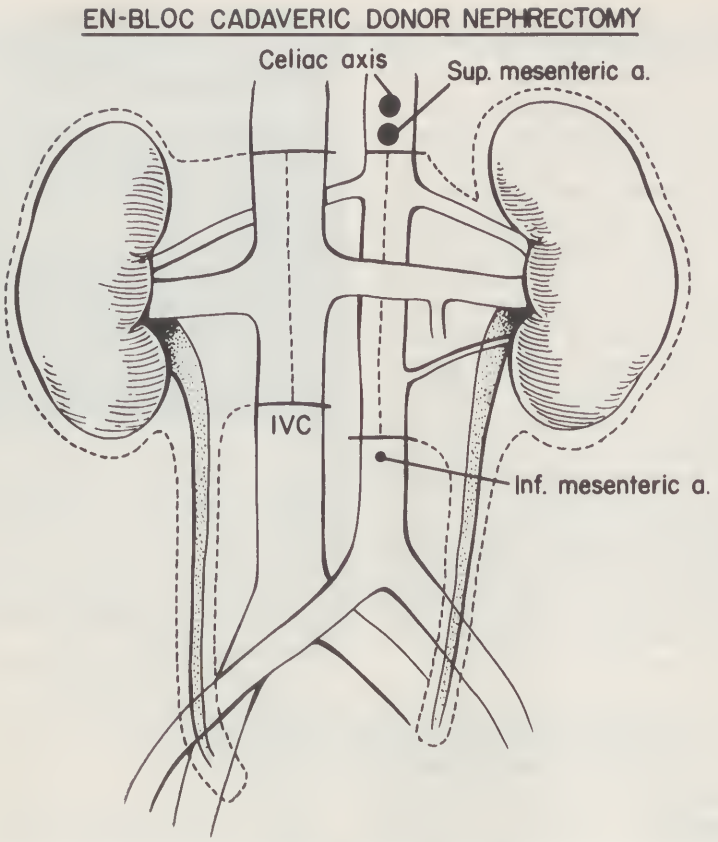

Fig. 3: En Bloc Cadaveric Donor Nephrectomy

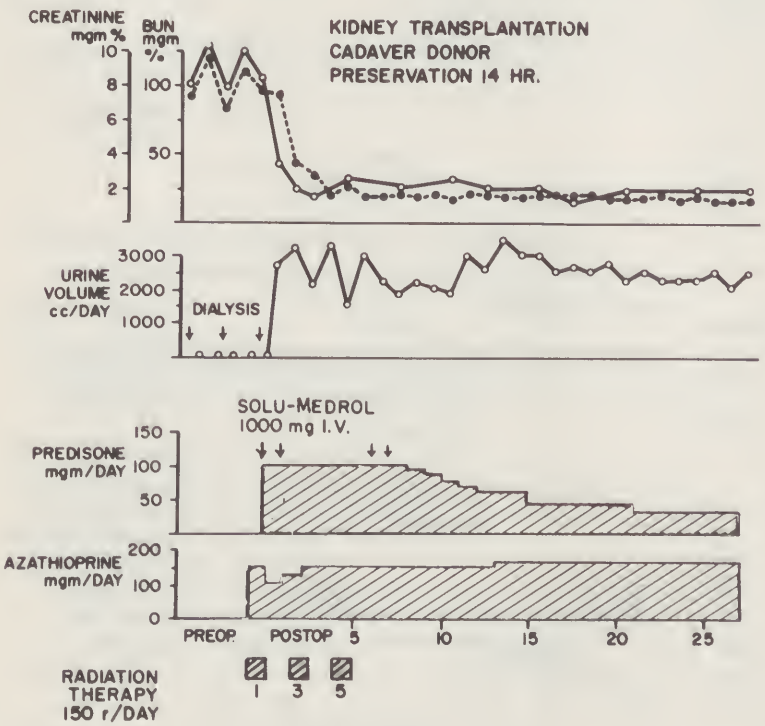

Fig. 4: Immediate postop course, human cadaver kidney transplantation

Basically, cryoprecipitated type specific plasma, prepared as recommended by Belzer,[3] was used to perfuse the kidneys by a continuous pulsatile flow at initial systolic pressure of 60-70 mmHg, which usually decreases to 40-50 mmHg within two hours as internal resistance decreases. Pulse rate was adjusted to 60/min. Perfusion flow rate of 100-200 ml/min./kidney was attained with normal adult size kidneys. Hypothermia was maintained at 7° to 8° C (Fig. 3).

Oxygen and carbon dioxide were added as needed to maintain a plasma PO_2 at approximately 150 mmHg, PCO_2 of 35 mmHg.

The pH was adjusted to a range of 7.35 - 7.45 by addition of $NaHCO_3$ at temperature of 7° to 8° C. Electrolytes, glucose and LDH levels of the perfusate were evaluated in all cases.

Results

Forty-three kidneys out of sixty-eight were transplanted successfully. Twenty-three kidneys were not used for various reasons (Table I): seven were discarded because of injuries to the kidneys including irreparable damage to renal arteries and veins and completely avulsed renal capsules during donor nephrectomy. Five kidneys were found to have congenital and acquired benign lesions including horse-shoe kidneys, cystic lesions, and severe unsuspected atherosclerosis. Five kidneys were discarded after a few hours perfusion because of poor perfusion parameters. Bacterial infection was a main reason for discontinuation of perfusion in two kidneys and viral infection in one.

Two eclamptic kidneys with borderline perfusion parameters were also discarded. One kidney could not be suitably matched to a recipient. Viability of donor kidneys was evaluated as follows:

1. Macroscopic findings: kidneys with gross defects were discarded before the initiation of perfusion. Careful re-examination of kidneys during perfusion is mandatory. It was not infrequent to find unrecognized accessory artery which was

TABLE III

Age Distribution of Cadaver Donors
(68 Kidneys from 38 Cadaver Donors

Age Distribution	
0 - 5	1
6 - 10	2
11 - 20	13
21 - 30	8
31 - 40	6
41 - 50	5
51 - 60	2
over 60	1

TABLE IV

Cadaver Donor's Blood Type
(68 Kidneys from 38 Cadaver Donors)

A	20
B	8
AB	0
O	10

ligated or severed during donor nephrectomy. Minor lacerations to renal arteries or veins were also found frequently and were repaired during perfusion. Viable kidneys appeared pale pink, and parenchymal pulsation was observed. Some increase in size was noted in all perfused kidneys.

2. Effect of warm and cold ischemia on renal preservation and posttransplantation function: Warm ischemia up to sixty-five minutes in our series did not affect perfusion parameters and postoperative function of transplanted kidneys (Table V). Immediate function and an excellent creatinine level of 1.6 mg percent within one week was observed on a kidney which was removed sixty-five minutes after cessation of renal arterial flow. However, we consider warm ischemia time up to sixty minutes to be safe under ordinary circumstances. Cold ischemia time which constitutes time interval from the initial flush perfusion of the kidney to the beginning of perfusion of up to four hours prior to perfusion was well tolerated.

3. Effect of perfusion time to renal function: In our series, perfusion time ranged from six hours to twenty-five hours. Two kidneys which were perfused for twenty-five hours underwent five days of oliguria immediately after transplantation. However, serum creatinine levels in the fourth week postoperatively were 1.2 mg percent and 1.5 mg percent respectively. Seventy-five percent of the kidneys were preserved in perfusion machine from twelve to twenty hours. Approximately twelve hours is usually sufficient to complete tissue typing and cross-matching as well as performing preoperative preparations required for the recipients.

4. Perfusion pressure and flow: The initial perfusion pressure was set at 60-70 mmHg in all cases regardless of flow rate. Perfusion pressure gradually decreased to 50-60 mmHg within two hours. Relatively low systolic pressure and wide pulse pressure was noted in kidneys which functioned immediately.

Most kidneys attained a perfusion flow rate of 100-200 ml/min. throughout the preservation. A persistently high perfusion pressure with narrow pulse pressure accompanied by poor flow rate (below 60 cc/min.) for more than four hours suggested severe vasoconstriction. Five kidneys were discarded because of inadequate perfusion.

5. pH of the perfusate: It was necessary to adjust perfusate pH, adding two to six milliequivalents of sodium bicarbonate at the beginning of perfusion. Further adjustment of pH was accomplished by adjusting carbon dioxide flow into the oxygenation chamber.

6. Electrolyte and glucose level of perfusate: There were no significant changes in electrolytes and glucose level of perfusion medium during preservation.

7. LDH level in the perfusate: The level of LDH ranged from 174 units to 560 units immediately after the kidneys were placed in the perfusion cassette. During perfusion, a steady rise in the perfusate LDH level ranged 300 units to 2,000 units. There was no correlation between perfusate LDH level and ultimate renal function.

8. Renal function after transplan-

TABLE V

Function of Preserved Cadaver Kidneys

Use of Kidney Perfusion Machine: 40

	Number of Kidneys	Warm Ischemia	Cold Ischemia	Perfusion Time	Perfusion Flow	Pressure at the end of Perfusion	Serum Creatinine four weeks Post-op.
Immediate Function	21	5-65 min.	5-120 min.	12-20 hr.	90-240 cc./min.	68/35-38/6	0.9-1.6 mg%
Oliguria less than 7 days	5	25-45 min.	50-90 min.	6-25 hr.	80-300 cc./min.	60/35-42/10	1.0-1.5 mg%
Prolonged oliguria more than 7 days	12	5-14 min.	15-240 min.	12-21 hr.	60-250 cc./min.	60/40-50/10	1.2-3.0 mg%

Use of Immersion Hypothermia (up to 4 hours): 2

Both kidneys developed prolonged oliguria up to 14 days
Serum creatinine four weeks post-op.: 1.0 and 2.3 mg% respectively

One patient died on post-operative day 3
One patient rejected kidney on post-operative day 7

tation: The time interval from cessation of renal arterial flow to the initiation of perfusion ranged ten minutes to four hours and ten minutes. Perfusion time ranged from six hours to twenty-five hours. Vascular anastomosis took seventeen to fifty minutes in our series.

Serum creatinine level four weeks after transplantation was below 2.0 mg percent in 90 percent of the cases. These are considered to have excellent renal function. Serum creatinine level ranged 2.0 mg percent - 3.0 mg percent in 10 percent of the cases, which constitutes one third of the kidneys in the group with prolonged oliguria of more than seven days (Table V).

One kidney was rejected on the seventh postoperative day. Transplant nephrectomy was performed immediately, and the patient was returned to chronic hemodialysis program. One patient died on the third postoperative day.

There were no technical failures during kidney preservation or transplantation in our present series.

Discussion

The routine use of the kidney preservation machine provides us with adequate time for more comprehensive matching of donors and recipients and for thorough preparation of the recipient prior to operation, as well as for evaluation of the functional integrity of the cadaver kidneys prior to transplantation. Blood transfusion using buffy coat-free red cells or frozen red cells were given during preoperative hemodialysis if indicated. Only two blood transfusions were required during transplant surgery.

Donor nephrectomy is standardized to eliminate possible injury to the renal hilum, renal capsule, and ureteral vessels during the procedure. At the same time, warm ischemia time has been minimized by efficient team work (Fig. 4).

Hypotensive episodes in the donor before nephrectomy were managed by volume replacement therapy. Indiscriminate use of vasopressor agents are eliminated by close cooperation between the donor's primary physician, intensive care unit staff, and transplant team. Kidneys which were removed from donors who had prolonged hypotensive episode and oliguria, were carefully evaluated during the perfusion and discarded if perfusion parameters were suboptimal. Emphasis has been placed on obtaining immediate function of cadaveric renal allografts in regard to three points: (1) easier immunosuppressive drug management, (2) early detection of rejection episodes, and (3) minimizing the overloading of the hospital hemodialysis unit.

Twenty-five percent (twelve) of all perfused kidneys developed prolonged oliguria of more than seven days duration. Perfusate LDH study was no help in evaluating viability of perfused kidneys in contrast to other reports.[4] The incidence of posttransplantation oliguria has been greatly diminished since the introduction of intracellular fluid (C_3) as an initial flush perfusate combined with a Plasmanate-Mannitol-Lasix infusion intraoperatively which was modified from Woods and associates.[5] One 250 ml unit of human plasma protein fraction was given approximately one hour prior to the revascularization of the donor kidney to increase intravascular volume if the recipient is not hypertensive. Intravenous "push" of 25 gm of Mannitol was administered at the beginning of vascular anastomosis, followed by intravenous "bolus" of 200 to 300 mg of Lasix. Up to 1,000 mg of Lasix and 50 gm of Mannitol have been given in some cases within twenty-four hours. In our experience, the immediate post transplant function of a human-kidney allograft is now quite predictable.

Dr. Yokoyama is assistant professor of surgery and director of Hahnemann's organ preservation laboratory. Dr. Bower, is professor of surgery and director of the kidney transplantation program. Dr. Wolferth is professor and chairman of the department of surgery, and Drs. Onesti and Swartz are professors of medicine in the division of nephrology. This paper was prepared by the departments of surgery and internal medicine at Hahnemann Medical College and Hospital. Portions of the paper were presented at the Philadelphia Academy of Surgery in February 1974.

Summary

Sixty-eight human kidneys, harvested in the eastern Pennsylvania-southern New Jersey area, have been received in the organ preservation laboratory, Hahnemann Medical College and Hospital, from January 1972, to December 1973.

Fifty-four kidneys have been stored for up to twenty-five hours on the Waters MOX-100 organ preservation apparatus, using profound hypothermia and pulsatile perfusion of cryoprecipitated plasma. During continuous perfusion, perfusion pressure, flow, plasma pH, PO_2, PCO_2, and perfusate LDH were evaluated.

Forty-three out of fifty-four kidneys preserved using this method were transplanted. Ninety percent of the kidneys have shown excellent function within four weeks after transplantation, with serum creatinine level of 0.9-1.9 mg percent. Serum creatinine of 2.0-3.0 mg percent was obtained in the remaining 10 percent.

The combination of C_3 solution as an initial flush and continuous pulsatile perfusion under profound hypothermia is the method of choice for preparing cadaveric kidneys for homotransplantation. □

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Stress evaluation of the painful, swollen "normal joint"

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With increasing frequency, orthopaedists are being asked to evaluate recently traumatized, but roentgenographically "normal" joints. These patients have usually been sent home from emergency rooms with elastic bandages, perhaps a set of crutches, and instructions to contact their family physicians if their symptoms persist. All too frequently these patients emerge in the orthopaedist's office one to six weeks later bitterly disappointed with persistent disability. Because there was "no fracture seen," they feel they must have experienced "only a sprain," and they expect full and complete recovery within days.

Approaching such patients to recommend further studies frequently meets with mild to moderate suspicion because "the

Figure 1. Stress x-rays showing abnormal widening of the medial joint line.

doctor said there was no fracture." These patients with localized or generalized swelling with a "normal" x-ray revealing no bony disruption should be considered to have a ligamentous injury, the extent of which can only be evaluated by careful physical exam and, if necessary, stress evaluation of appropriate supporting structures. On occasion, proper evaluation can require local, regional block, or even general anesthesia.

Frequently these patients experience increasing edema with pain and a subsequent moderate ecchymosis, particularly in weight bearing joints. A careful physical examination with elucidation of the most tender areas is the key to determining the mode and method of subsequent ligamentous evaluation. Impressions of laxity or instability gained on physical examination and suggesting severe ligamentous injury can be confirmed by stress x-rays. In the case of the knee, valgus and varus stress x-rays performed in 30 degrees of flexion to relax the cruciate ligaments can be quite helpful. To assess the medical aspect of the knee, the thighs are wrapped together with several six inch elastic bandages for stabilization and the tibiae held abducted while the film is taken.[1] For varus stress, a thick blanket or bolster is inserted between the thighs and the tibiae are adducted, stressing the lateral aspect of the joint.[1] In general, instability of more than 10 degrees as compared with the normal knee is indicative of a severe ligamentous injury requiring operative repair.

Similar eversion and inversion views of the ankle in slight plantar flexion with comparison views of the opposite, uninjured extremity are very helpful.[2,3] The technique can be applied to the thumb, the acromioclavicular joint, or almost any other joint in the body.[4,5]

Case I

A 19-year-old white male was clipped playing football and experienced immediate pain in his knee. When brought to the emergency room shortly thereafter, there was surprisingly little pain and swelling because ice had been applied. The patient was convinced his injury was only minor. X-rays of the knee were within normal limits and did not

Figure 2. Arthrography showing extravasation of dye confirming the diagnosis of acute medial collateral ligament disruption.

show a great deal of soft tissue swelling. Valgus stress films, however, elucidated a moderate tear of the medial collateral ligament which was confirmed by arthrography and subsequently in surgery (Figures 1 and 2).

Case II

A 20-year-old white male jammed his thumb at work and experienced immediate pain on the ulnar side of

This paper was prepared by the department of surgery of the Milton S. Hershey Medical Center, Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

Figure 3 A and B: Anteroposterior views of the metacarpophalangeal joint of the thumb with and without stress confirming the diagnosis of complete disruption of the ulnar collateral ligament.

the metacarpal phalangeal joint. X-rays taken in the emergency room were within normal limits, but because of persistent disability he was sent to the orthopaedic clinic for further evaluation. Stress x-rays revealed marked ligamentous laxity, and a complete tear of the ulnar collateral ligament was confirmed in surgery and subsequently repaired (Figures 3A and 3B).

Case III

A 17-year-old high school quarterback sustained an inversion injury to his right ankle while playing football in September 1973. X-rays in the emergency room were interpreted as being within normal limits. The patient was unable to resume activity after seven days of self-imposed rest. Stress x-rays without anesthesia showed marked instability that was not duplicated on the opposite extremity. Open repair of the anterior talofibular and calcaneofibular ligaments was performed under general anesthesia, and the patient returned to full activity eight weeks later and is now back in competitive sports as a starting high school quarterback (Figures 4A and 4B).

Discussion

Many physicians are not aware of the chronic disability that can ensue for the active athlete, laborer, or busy housewife who has to live with a chronically unstable joint. Delay in further evaluation is often prolonged by the patients themselves because of the "normal" x-ray report. Some orthopaedists have gone far enough to suggest that the diagnosis of *sprain* be eliminated from medical vernacular, or at least confined to those cases where appropriate stress x-rays have ruled out a significant tear of supporting structures. When stress x-rays are obtained, comparison views of the normal or uninjured extremity are essential for a complete evaluation. The absence of these comparison views has often led to the erroneous conclusion that stress x-rays are overemphasized because of the lack of rigid criteria of normalcy.

Trauma to any joint must be approached in a systematic and aggressive fashion to provide a functional result. This requires a thorough evaluation of supporting soft tissues as well as skeletal structures. Severe ligamentous injuries about joints can require prolonged immobilization by casting and often surgery for optimal recovery. Indiscriminate treatment can be responsible for significant disability. The addition of stress evaluation on physical examination and confirmatory stress x-rays should lead to a more accurate diagnosis and adequate treatment of these injuries. □

Figure 4 A and B: Anteroposterior views of the ankle with and without stress showing disruption of the fibular collateral ligaments.

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• Indicates membership in the Pennsylvania Medical Society at time of death.

• **John Askey,** Oil City; Medico-Chirurgical College of Philadelphia, 1915; age 85; died September 26, 1974. His wife, a daughter, and a sister survive him.

• **Alfred W. Crozier, Jr.,** Pittsburgh; University of Pittsburgh School of Medicine, 1933; age 67; died September 11, 1974. He was surgical chief of staff at Bradock General Hospital and was a member of the American College of Surgeons. He is survived by his wife, two daughters, two sisters, and a brother.

• **John U. Fehr,** Sellersville; Jefferson Medical College, 1941; age 58; died September 10, 1974. He was chief of the department of urology at Grand View Hospital. Survivors include his wife, two daughters, a son, a sister, and a brother.

• **Samuel Friedmann,** Scranton; Hahnemann Medical College, 1910; age 92; died September 4, 1974. He was former chief surgeon at Community Medical Center. Survivors include his wife and two sons, one of whom is Elihu Friedmann, M.D., of Scranton.

• **William V. Hostelley,** Rydal; Hahnemann Medical College, 1930, age 65; died September 8, 1974. A former director of the department of otolaryngology at Frankford Hospital, he was a fellow of the American College of Surgeons and a past president of the Philadelphia Laryngological Society. He is survived by a daughter and two sons, one of whom is Richard T. Hostelley, M.D., Washington, D.C.

• **Jack A. Grebe,** Tyrone; University of Pennsylvania School of Medicine, 1945; age 54; died September 8, 1974. He had practiced medicine in Tyrone for twenty-five years. He is survived by his wife, three daughters, two sons, two sisters, and a brother.

• **Ervant Kapeghian,** Vestal, N.Y.; Maryland Medical College, 1911; age 88; died September 25, 1974. He had practiced medicine in West Philadelphia and Kensington for fifty years. A daughter and a son survive him.

• **Morris Kramer,** Easton; University of Vermont College of Medicine, 1937; age 61; died September 18, 1974. He was an associate in internal medicine and in cardiology at Easton Hospital. Dr. Kramer was certified by the American Board of Internal Medicine and was a fellow of the American College of Physicians and the American College of Cardiology. He is survived by his wife, a daughter, a son, two sisters, and a brother.

• **William T. Lemmon,** Woodbury, N.J.; Jefferson Medical College, 1921; age 77; died September 1, 1974. Prior to his retirement in 1969, Dr. Lemmon was chief of surgery at Doctors Hospital and president and chief of staff of the former Woodbury Memorial Hospital. He is survived by his wife; four daughters; a son, William T. Lemmon, Jr., M.D., Philadelphia; and a sister.

• **Ralph H. Merkel,** Pottstown; Jefferson Medical College, 1919; age 82; died September 25, 1974. He had practiced medicine in Pottstown for forty-eight years prior to his retirement in 1972. He is survived by a daughter and two sisters.

• **William J. Murray,** Johnstown; Jefferson Medical College, 1920; age 79; died September 11, 1974. He was a past president of the Cambria County Medical Society and a fellow of the American College of Surgeons. Information regarding survivors is not available.

• **William Myers,** Pittsburgh; Maryland Medical College, 1936; age 65; died September 22, 1974. He is survived by his wife and two sisters.

• **Roy R. Norton,** Sharon; Jefferson Medical College, 1907; age 93; died August 20, 1974. He had retired after sixty years of medical practice. He is survived by a son and a daughter.

• **Arthur W. Phillips,** Emlenton; University of Pennsylvania School of Medicine, 1916; age 86; died September 26, 1974. His wife survives him.

• **S. Gilmore Pontius,** Lancaster; University of Pennsylvania School of Medicine, 1918; age 82; died August 28, 1974. He was former chief of surgery at Lancaster General Hospital and was a past president of the Lancaster County Medical Society. He is survived by his wife; a daughter; and two sons, one of whom is John Gilmore, M.D., Lancaster.

• **Wilhelmina S. Scott,** Lancaster; University of Pennsylvania School of Medicine, 1923; age 75; died September 29, 1974. She had been head of the department of radiology at Lancaster General Hospital for twenty years. Dr. Scott was a member of the executive board and the board of directors of the American Cancer Society. She is survived by a son, a daughter, and a sister.

• **Kenneth C. Sharretts,** Greenville; Johns Hopkins University School of Medicine, 1936; age 62; died September 18, 1974. He had practiced surgery for eighteen years. Survivors include his wife, two daughters, a son, a stepdaughter, a stepson, and four brothers.

Daniel F. Downing, Philadelphia; Boston University School of Medicine, 1945; age 57; died March 16, 1974. He was certified by the American Board of Pediatrics and the American Board of Pediatric Cardiology. He was a member of the American College of Physicians, the American College of Cardiology, and the International College of Surgeons. His wife survives him.

Stephen A. Flaherty, McKeesport; St. Louis University School of Medicine, 1934; age 64; died March 23, 1974. His wife survives him.

Frederic H. Steele, Atlantis, Florida; Jefferson Medical College, 1934; age 66; died August 21, 1974. He served as urologist and attending surgeon at J. C. Blair Memorial Hospital in Huntingdon for many years and was medical director and chief surgeon at the Huntingdon State Correctional Institution. He was a past president of the Huntingdon County Medical Society, a fellow of the American Urologic Association, the Academy of International Medicine, the American College of Surgeons, and was certified by the American Board of Associates of Abdominal Surgeons. He is survived by his wife and three children.

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Proceedings 125th Annual Session of the House of Delegates

Pittsburgh, October 10-12, 1974

(Secretary's Note: Favorable action by the House of Delegates on the recommendations of the reference committees can be assumed unless reported otherwise.)

The Opening Session of the House, October 10, 1974

The speaker called the opening session of the House to order at 1:06 p.m., Thursday, October 10, 1974, in the ballroom of the William Penn Hotel, Pittsburgh. After hearing a report from the chairman of the Committee on Credentials (John G. Hallisey, M.D., Beaver County) that a quorum was present, John B. Lovette, M.D., speaker, called upon Robert Poole, III, M.D., Chester County, past chairman of the Pennsylvania Medical Society Committee on Medicine and Religion and past member of the American Medical Association Committee on Medicine and Religion, to offer the invocation.

Report of the Speaker

Dr. Lovette presented the following report to the House regarding four recommendations originating at the 1972 House meeting.

"At the conclusion of the 1972 House of Delegates meeting, R. William Alexander, M.D., delegate from Berks County, made four recommendations, which were adopted by the House and referred to the speaker for implementation. Those recommendations were:

"(1) That the Chair assign designated seats or seating areas to county delegations. As you know, this recommendation was implemented last year. Seating is along councilor district lines as indicated in the charts on pages ii and iii of the *Official Reports Book*. Each year those councilor districts which find themselves at the very front of the room will next year move to the back of the room; and everyone else will move up, so that eventually each delegation will have an opportunity to enjoy front-row seating. The questionnaire which we provided on the final day of the meeting last year showed that you approve of this arrangement. (2) Another recommendation was that the microphones of the House be numbered sequentially. The microphones are in the center aisle and there are three of them: one, two, three. (3) That identifying cards be provided for dignitaries on the platform. The implementation of this recommendation is self-evident. (4) That the Credentials Committee accomplish its validation of credentials through a mail preregistration process, thus avoiding the need for a member of the Credentials Committee to be on hand in order for a delegate to register. We studied the matter in detail with both staff and Legal Counsel and the AMA. It was our recommendation last year that before going to a mail preregistration, we authorize staff to handle routine registrations, just as the AMA does. This seems to have worked, and we will continue unless we hear objections from you. The Credentials Committee itself meets at an appointed time prior to each session of the House to go over any problems. It is my impression that under this system the registration desk has been opened at the convenience of the delegates and that no serious delays have been experienced.

"Again this year, as last year, we will provide you with a questionnaire at the conclusion of the Annual Business Session on which you may indicate your reaction to various elements of the meeting. D. Ernest Witt, M.D., vice speaker, and I find these very helpful and ask that you do take the time to fill them in."

Committee on Rules

Arthur J. Patterson, M.D., chairman of the Committee on Rules (Greene County) presented the following written report:

"The Committee on Rules met and unanimously approved the adoption of the Standing Rules of the House of Delegates of the Pennsylvania Medical Society as published on page 4 of the 1974 *Official Reports Book* to the House of Delegates of the Pennsylvania Medical Society, with the exception of Standing Rule No. 1, which sets forth the order of business of the House. In consultation with the Speaker of the Pennsylvania Medical Society's House of Delegates, your reference committee has considered a revision of the meeting schedule of the second meeting. The purpose of this change is to assure that proper consideration be given to the activities of the Pennsylvania Medical Care

Foundation. Your reference committee is aware that last year's schedule made it difficult for delegates to participate as administrative members of the Pennsylvania Medical Care Foundation, and the revised meeting schedule for the second meeting assures that proper attention will be given to this responsibility of the delegates. In response to the specific request of the reference committee for objections to this schedule, no objections were heard. The suggested meeting schedule is as follows:

1. Call to Order
2. Report of Committee on Credentials
3. Reference Committee on Constitution and Bylaws
4. Reference Committee on Medical Service "B"
5. Annual Meeting of the Administrative Members of the Pennsylvania Medical Care Foundation
6. Nomination and/or election of officers
7. Report of the Committee to Nominate Delegates and Alternates to the American Medical Association
8. Introduction of additional supplemental reports and resolutions
9. Reports of reference committees
10. Announcements
11. Recess

Mr. Speaker, I recommend that the Standing Rules of the House be adopted as printed with the above amendment to Standing Rule No. 1.

"Mr. Speaker, your reference committee has considered the supplemental report received from the Second Councilor District contained on Page 97 of the *Official Reports Book*. This report asks that a plan of seating should be operative whereby the executive secretary may sit with delegates from the counties they represent. Your reference committee heard considerable testimony on this question, which indicates a desire on the part of many county medical societies to have the benefit of assistance from their executive secretaries on the floor of the House of Delegates. It is the feeling of these counties that the quality of decisions reached would be enhanced by the services provided to their delegation by their executive secretary. Your reference committee is cognizant of the policy of the American Medical Association's House of Delegates, at which staff persons may not sit with their delegation.

Your reference committee, on the basis of testimony presented both by counties that have executive secretaries and those that do not, and testimony presented by the Speaker of the House, recommends that executive secretaries be seated with their delegation."

Necrology Report

The House stood in tribute following the Necrology Report presented by Cyrus B. Slease, M.D., Armstrong County, chairman of the Board of Trustees:

"At this time it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago, but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical society bulletins and in PENNSYLVANIA MEDICINE, the journal of the Pennsylvania Medical Society.

"Among those who passed away this year was a member who was known to all of the members of this House of Delegates and, indeed, who was a personal friend of many of the members present today—Dr. Ralph C. Wilde—president of the Pennsylvania Medical Society.

"From September 1, 1973, to August 31, 1974, we have lost by death 208 members: eleven not over 50 years of age; 104 between fifty-one and seventy; and ninety-three in the group aged seventy-one to over ninety. Of these 208 members, eighty-one were associates, most of whom were sixty-five years of age or over. The necrology report at the last annual session reported the loss of 217 members.

"May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

PaMPAC Presentation

R. William Alexander, M.D., Berks County, chairman of the PaMPAC board of directors, presented an informational report to the House. Dr. Alexander's remarks are attached as *Appendix A*.

Announcements

D. Ernest Witt, M.D., Columbia County, vice speaker of the House of Delegates introduced officers of the Society, members of the Judicial Council, and members of the Board of Trustees and Councilors.

Approval of Proceedings

The Proceedings of the 124th Annual Meeting of the Society in Philadelphia, October 18-20, 1973, found on pages 61 through 119 of the December 1973 issue of PENNSYLVANIA MEDICINE were approved.

Address of the President

A. Reynolds Crane, M.D., Philadelphia County, president, presented a report on his plans for the coming year. Dr. Crane's speech was referred to the Reference Committee on Reports of Officers, with the exception of the recommendations dealing with Blue Shield and no-fault insurance, which were referred to the Reference Committee on Medical Service "A". A recommendation concerning unified membership was referred to the Reference Committee on Constitution and Bylaws. The text of Dr. Crane's address appeared in the November 1974 issue of PENNSYLVANIA MEDICINE.

Report of the AMA Delegation

As required by the Resolved portion of Resolution 71-1: AMA Delegation Report and Plans, the House received a brief report from the chairman of the PMS Delegation, Malcolm W. Miller, M.D., Philadelphia.

"I call your attention to the complete report of the Pennsylvania Delegation to the American Medical Association which appears on pages 91 and 92 of the *Official Reports Book*. My remarks today will be confined to those items which I believe should be emphasized.

The Pennsylvania Medical Society was represented by a full complement of delegates at the Clinical Meeting of the AMA in Anaheim, California, in December 1973 and at the Annual Meeting in Chicago in June 1974. Your delegation continues to remain active and energetic in the organizational affairs of the AMA.

"The 1974 meeting in Chicago marked the conclusion of Dr. Russell B. Roth's term as president of the AMA. Dr. Roth served the AMA with distinction, and I believe history will record him as one of the AMA's outstanding spokesmen. At the June meeting, Dr. William Y. Rial, of Swarthmore, was reelected vice speaker of the AMA House of Delegates; and, as I indicate in our official report, it will not be a surprise to learn that he served with distinction in the AMA House of Delegates.

"I would like to call your attention to the fact that Dr. William B. West, of Huntingdon, and Dr. William A. Limberger, of West Chester, have chosen not to be renominated as delegates this year. Dr. West served as a delegate for thirteen years, and Dr. Limberger for nine years. The contributions of these two physicians, not only in the Pennsylvania Medical Society but at the AMA level, have been invaluable; and they will be missed as members of the Pennsylvania Delegation to the AMA and should receive the plaudits of this House of Delegates.

"As we indicate in our report, three resolutions were submitted by the Pennsylvania Delegation to the AMA House of Delegates at the December meeting, as mandated by the 1973 House of Delegates of the PMS. The fate of these resolutions is outlined in our report on page 91.

"As most of you know, one of the key issues discussed at both the Anaheim and Chicago meetings was Professional Standards Review Organization. I would urge you to read very carefully that section of the report which appears on page 92 in which we outline the position finally taken by the AMA with regard to PSRO at the June meeting. It should be emphasized that it is our interpretation that the new policy provides that in the event the PSRO program does, in fact, adversely affect patient care or conflicts with AMA policy, that the Board of Trustees of the AMA will be instructed to use all legal and legislative means to rectify shortcomings.

"As is noted on your schedule, the Pennsylvania Delegation will hold an open hearing again this year—tomorrow morning at nine o'clock in the Allegheny Room of this hotel. Every member is welcome and I personally urge you to attend to let the delegation have the benefit of your opinions."

Pennsylvania Delegation Open Hearing

It was announced that the Pennsylvania Delegation to the AMA would hold an open hearing Friday morning at 9:00 a.m. in the Allegheny Room, with the Pennsylvania Delegation sitting as a special committee, Dr. Miller, chairman, presiding. The purpose of the hearing was to afford members an opportunity to ask questions of the delegation and to make their views on the AMA known.

Candidates for Vice Speaker

Dr. Lovette read the Resolved portion of Resolution 73-26: "Resolved, that the Bylaws of the Pennsylvania Medical Society be changed to mandate two or more candidates for the office of vice speaker." Dr. Lovette announced that the amendment had been cast into language and would be voted upon the first thing Friday morning. Depending upon the sense of the House, a slate of two candidates for vice speaker may or may not be mandated later in the afternoon at the time of nominations.

(Secretary's Note: The proposed amendments failed to carry and thus there was no requirement that at least two candidates be presented for the office of vice speaker.)

Distinguished Guests

The following distinguished guests were presented to the House: William R. Schultz, M.D., past president, Ohio State Medical Association; Ralph S. Emerson, M.D., president elect, Medical Society of the State of New York; William E. Gilmore, M.D., president, West Virginia State Medical Association; Calvin B. Hearne, M.D., secretary, Medical Society of Delaware; Vernon C. Buckley, D.O., president, Pennsylvania Osteopathic Medical Association; William A. Booth, D.D.S., president, Pennsylvania Dental Association; George S. Maggio, president, Pennsylvania Pharmaceutical Association; Mrs. Irene Goll, president, Pennsylvania Chapter, American Association of Medical Assistants.

Address of the Official AMA Representative

William Y. Rial, M.D., vice speaker of the American Medical Association's House of Delegates, and past speaker of the PMS House of Delegates, addressed the Pennsylvania Medical Society House of Delegates. Dr. Rial voiced his support of the unified membership amendment prepared by the Committee on Constitution and Bylaws. His remarks were received for information.

Acceptance of Reports and Resolutions

The material contained in the 1974 *Official Reports Book* was accepted. The following announcement was made with regard to the Pennsylvania Medical Care Foundation: "As you know, according to the bylaws of the Medical Care Foundation, the members of the PMS House of Delegates are also the administrative members of the Pennsylvania Medical Care Foundation. In the packet you will find the 1974 Annual Report of the Board of Directors of the Pennsylvania Medical Care Foundation. It is referred to the Reference Committee on Medical Service "B".

"It is the recommendation of the Chair that the House determine to hold the annual meeting of the Pennsylvania Medical Care Foundation tomorrow afternoon. We recommend that immediately after concluding the Reference Committee Report on Constitution and Bylaws, the House consider the Reference Committee Report on Medical Service "B". At the conclusion of Medical Service "B" we believe that the House should recess and immediately convene the meeting of the administrative members of the Foundation. Following the annual meeting of the Foundation, we would then reconvene as the House of Delegates and continue with nominations and/or elections."

The Chair called upon Matthew Marshall, Jr., M.D., Allegheny County, president, Pennsylvania Medical Care Foundation, for a few remarks concerning the annual report of the Foundation.

The following supplemental reports were contained in the *Official Reports Book*. They became the official business of the House. (1) Supplemental Report A, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers). *See Appendix B.* (2) Supplemental Report B, Board of Trustees and Councilors (Referred to Reference Committee on Medical Service "A"). *See Appendix C.* (3) Supplemental Report C, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers). *See Appendix D.* (4) Supplemental Report D, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers). *See Appendix E.* (5) Supplemental Report E, Board of Trustees and Councilors (Referred to Reference Committee on Medical Service "A"). *See Appendix F.* (6) Supplemental Report F, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers). *See Appendix G.* (7) Supplemental Report, Second District (Referred to Reference Committee on Rules). *See Appendix H.*

The following supplemental reports in the delegates' packets were received as the business of the House. (1) Supplemental Report G, Board of Trustees and Councilors (Referred to Reference Committee on Medical Service "A"). *See Appendix I.* (2) Supplemental Report H, Board of Trustees and Councilors (Referred to Reference Committee on Reports of Officers with the exception of Item 2, *re* Pennsylvania Medical Cooperative, which was referred to Reference Committee on Public Service). *See Appendix J.* (3) Supplemental Report I, Board of Trustees and Councilors (Referred to Reference Committee on Governmental Relations). *See Appendix K.* (4) Supplemental Report, Council on Governmental Relations (Referred to Reference Committee on Governmental Relations). *See Appendix L.* (5) Supplemental Report, Council on Public Service (Referred to Reference Committee on Public Service). *See Appendix M.* (6) Supplemental Report, Committee on Relationships with Allied Professions (Referred to Reference Committee on Education and Science). *See Appendix N.* (7) Annual Report of the Educational and Scientific Trust (Referred to Reference Committee on Education and Science). *Available upon request.* (8) Report of Pennsylvania Blue Shield (Referred to Reference Committee on Medical Service "A"). *Available upon request.* (9) Supplemental Report, Pennsylvania Blue Shield (Referred to Reference Committee on Medical Service "A"). *Available upon request.* (10) Budget calculations for 1974 (Referred to Reference Committee on Reports of Officers). *Available upon request.*

Finance Committee Report

George A. Rowland, M.D., Columbia County, chairman, Finance Committee, presented the following report of the Finance Committee of the Board of Trustees and Councilors, which was referred to the Reference Committee on Reports of Officers.

"A copy of the proposed budget for 1975, as approved by the Board of Trustees, has been distributed for your information. It also contains the comparative figures of the budget approved for 1974, as well as the actual expenditures for the period January 1 through June 30, 1974, which shows a deficit of $6,360 for the six-month period. Since this statement was prepared, the financial situation has improved considerably. We now anticipate a surplus of approximately $50,000. This has resulted from the tremendous increase in interest rates available to us as well as the reimbursement from the federal government for management services of the Susquehanna Valley Regional Medical Program. In 1974, without this reimbursement, we would be projecting a deficit of some $15,000. I believe this underscores the tenuous nature of the surplus we are registering this year.

"The budget for 1975 is based on the current annual assessment of $100 per full dues-paying member and reflects a deficit of $203,728. It includes reimbursement from the federal government for a six-month period since the funding for SVRMP carries them through June 30, 1975. It is expected that the Regional Medical Program will be terminated at that time.

"We have held two meetings on the budget and were unable to make more than minor reductions in the projected deficit. The committee and the Board of Trustees believes the budget requests of the various councils and committees to be reasonable and to represent the funds they will need to carry out mandated programs. Councils and committees have exercised great care in expenditures in the past. With their continued help we hope to keep the deficit to a minimum.

"However, there are resolutions which this House is going to consider which carry an estimated additional cost of $59,500. A constitutional amendment before this House would establish an Emeritus membership category, replacing the Associate classification. This change would require no dues payment of the concerned members, and since those who are eligible for Senior Active membership would also be eligible for this category, it could result in loss in dues revenue of up to $57,000. The Council on Public Service is requesting the Society to provide financial backing for initial capitalization of the Cooperative, should their proposed extension of the recruitment program fall short. This could amount to $80,000 but will probably be less. These items alone could almost double the

1975 projected deficit. No one can measure at this time the fiscal effect of unified membership, which, incidentally, the Board supports, or the effect of the continuing education requirement. Their impact could be short-range, minimal, or permanent. Unquestionably these issues add deeper ambiguity to an already strained fiscal picture.

"It appears at least a $25 increase in the annual assessment will be necessary for next year, based on the budget before you. I emphasize that this budget does not take into account the various reports and resolutions and other items of business before this House which have fiscal implications. A definite recommendation will be made at the final session of the House. What the exact figure will be depends on what you do here during the next few days. In this regard, you have in your packets a comparative study of dues for state medical associations, which I recommend for your reading.

"If there are any questions regarding the budget or the financial condition of the Society, I strongly urge you to attend the hearing of the Reference Committee on Reports of Officers where members of the Finance Committee will be available to hear your opinions and to attempt to answer any questions you might have. Thank you."

Comparison of Current Dues of
State Medical Associations—Informational

Alaska	$450	Minnesota	125
Nevada	260	Wyoming	125
District of Columbia	220	Mississippi	125
Idaho	210	Ohio	125
Hawaii	205	Washington	122
Montana	200	Oklahoma	120
Iowa	200	New Hampshire	120
South Carolina	180	Indiana	110
Wisconsin	175	Maryland	110
South Dakota	175	Georgia	100
Utah	165	Nebraska	100
Michigan	155	New York	100
Oregon	155	Pennsylvania	100
Colorado	150	Rhode Island	100
North Dakota	150	Vermont	100
Delaware	140	West Virginia	100
California	135	New Jersey	100
New Mexico	135	Louisiana	100
Illinois	130	North Carolina	95
Kentucky	130	Missouri	90
Arizona	130	Massachusetts	85
Texas	130	Virginia	85
Alabama	125	Tennessee	80
Arkansas	125	Florida	75
Kansas	125	Connecticut	75
Maine	125	Puerto Rico	73

Resolutions

The following resolutions were received less than thirty days before the meeting of the House of Delegates and were accepted by the House as business:

Resolution No. 74-12

Subject: DPW Noncooperation with physicians' requests for payments
Introduced by: David N. Farber, M.D., delegate, in behalf of the Berks County Medical Society
(Referred to Reference Committee on Medical Service "A")

Resolution No. 74-13

Subject: Hypertension
Introduced by: John H. Moyer, III, M.D., delegate, Philadelphia County
Author: John H. Moyer, III, M.D.
(Referred to Reference Committee on Education and Science)

Resolution No. 74-14

Subject: Beginning of Human Life
Introduced by: John D. Lane, M.D., delegate, Bucks County Medical Society
Author: John D. Lane, M.D.
(Referred to Reference Committee on Education and Science)

Resolution No. 74-15

Subject: Doctors of Osteopathy being members of county medical societies and not members of the Pennsylvania Medical Society
Introduced by: Irving Williams, M.D., in behalf of the Union County Medical Society
Author: J. Preston Hoyle, M.D.
(Referred to Reference Committee on Constitution and Bylaws)

Resolution No. 74-16

Subject: Reaffirmation of the Usual, Customary, and Reasonable Fee Concept
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: Matthew Marshall, Jr., M.D.
(Referred to Reference Committee on Medical Service "A")

Resolution No. 74-17

Subject: Reevaluation of PMS Continuing Education Program
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: James R. Dorenburg, M.D.
(Referred to Reference Committee on Education and Science)

Resolution No. 74-18

Subject: Tribute to the late Ralph C. Wilde, M.D.
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: Michael P. Levis, M.D.
(Adopted by the House without referral)

"WHEREAS, Dr. Ralph C. Wilde served his profession and community as an outstanding teacher, surgeon, and leader; and

WHEREAS, Dr. Wilde exemplified by his compassion, understanding, and professional skills that to which all physicians of good will aspire; and

WHEREAS, Dr. Wilde imparted diligence and integrity to those students of surgery fortunate enough to work with him; and

WHEREAS, Dr. Wilde gave so willingly of his time and energy to enhance and enrich those professional organizations he served; and

WHEREAS, Dr. Wilde served with uncommon distinction as the 124th president of the Pennsylvania Medical Society in 1973-74 and president of the Allegheny County Medical Society in 1971-72; therefore be it

RESOLVED, That his untimely death on July 10, 1974, be proclaimed a great loss to the Pennsylvania Medical Society, the city of Pittsburgh, and especially his family; and be it further

RESOLVED, That a copy of this expression of respect and appreciation be suitably inscribed and forwarded to his bereaved family."

Resolution No. 74-19

Subject: Obstetrical Fee Coverage
Introduced by: Henry H. Fetterman, M.D., on behalf of the Pennsylvania Section of the American College of Obstetricians and Gynecologists
(Referred to Reference Committee on Medical Service "A")

Resolution No. 74-20

Subject: Confidentiality of Medical Records
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: Michael P. Levis, M.D.
(Referred to Reference Committee on Education and Science)

Resolution No. 74-21

Subject: Recommendations to Blue Shield for a Meaningful Doctors' Plan
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: Jerome Chamovitz, M.D.
(Referred to Reference Committee on Medical Service "A")

Resolution No. 74-22

Subject: Correction of Inequities Existing between Surgical and Nonsurgical Fees in the Plan C Fee Schedule
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: Jerome Chamovitz, M.D.
(Referred to Reference Committee on Medical Service "A")

Resolution No. 74-23

Subject: Medical Audit and Utilization Review Procedures
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: Matthew Marshall, Jr., M.D.
(Referred to Reference Committee on Medical Service "B")

Attendance Slips

Legal Counsel has determined that for purposes of the record, the registration data maintained by the Credentials Committee is sufficient. Therefore, attendance slips are not being provided. At the same time, we wish to remind delegates that they are free to call for a roll call vote at any time.

Reference Committees

Reference Committees for the 1974 Annual Session of the House of Delegates are listed below:

Constitution and Bylaws

*R. Robert Tyson (Philadelphia), Chairman
*Robert W. Allen (Mercer)
*Betty L. Cottle (Blair)
*Patrick H. Hughes (Allegheny)
*John D. Lane (Bucks)
Robert Poole (Chester), Alternate

Education and Science

*John Y. Templeton (Philadelphia), Chairman
*Frank J. Dracos (Orthopaedics)
*William K. Sieber (Allegheny)
*Joel Abramovitz (University of Pittsburgh)
*Charles K. Zug (Northampton)
William A. Shaver (Lebanon), Alternate

Credentials

John G. Hallisey (Beaver), Chairman
John E. Kenvin (Lehigh)
J. Campbell Martin (Columbia)
Leon Reinstein (Physical Medicine and Rehabilitation)
Walter B. Watkin (Huntingdon)
Charles E. Cleland (McKean), Alternate

Public Service

*Richard L. Huber (Lackawanna), Chairman
*Clayton C. Barclay (Schuylkill)
Luther W. Brady (Philadelphia)
*Arthur I. Murphy (Allegheny)
*F. Gregg Ney (Butler)
*Charles R. Sloan (Fayette), Alternate

Governmental Relations

*Rex A. Pittenger (Allegheny), Chairman
*Paul S. Friedman (Philadelphia)
*Richard A. Peters (Warren)
*John P. Whiteley (York)
Melvin Williams (Indiana)
*Sami I. Michael (Carbon), Alternate

Reports of Officers

*David L. Miller (Clarion), Chairman
David N. Farber (Berks)
*Michael P. Levis (Allegheny)
*David L. Mudrick (Delaware)
Charles C. Wolferth, Jr. (Philadelphia)
*David F. Gillum (Tioga), Alternate

Tellers

Frank A. Belmont (Perry), Chairman
Jon S. Adler (Washington)
John C. Cavender (Susquehanna)
James E. Hadley (Venango)
Clifford B. Lull, Jr. (Jefferson)
Roderick R. McLeod (Armstrong)
Edward N. Moser (Lycoming)
Paul J. Schaner (Anesthesiology)

Medical Service "A"

*Lester A. Dunmire (Allegheny), Chairman
Michael D. McGuire (Montgomery)
*Thomas P. Petrick (Westmoreland)
*Robert E. Rawdon (Mifflin-Juniata)
*George P. Rosemond (Philadelphia)
*Frederick R. Gilmore (Clearfield), Alternate

Medical Service "B"

*R. Edward Steele (Dauphin), Chairman
*James R. Dornenburg (Allegheny)
*Herbert Fellerman (Luzerne)
*William W. Gress (Cambria)
*Edward J. Resnick (Philadelphia)
John P. Mraz (Erie), Alternate

Rules

*Arthur J. Patterson (Greene), Chairman
*John J. Corcoran (Lancaster)
Lawrence D. Ellis (Allegheny)
George A. Hahn (Philadelphia)
*Charles J. H. Kraft (Wyoming)
*Robert F. Beckley (Clinton), Alternate
**Indicates those members who signed the report.*

Alternates to Reference Committees—Again this year the speaker appointed, along with the regular five members of each reference committee, one alternate. These alternates were so notified and received all pertinent materials relating to their reference committee. The purpose is to make available to the committee a substitute familiar with the material, in the event that one of the regular committee members is unable to attend the meeting.

Remarks of President of Woman's Auxiliary

Mrs. Frederick R. Gilmore, president, Woman's Auxiliary to the Pennsylvania Medical Society, addressed the House on the occasion of the Auxiliary's 50th Anniversary, and her remarks were referred to the Reference Committee on Public Service. *Available upon request.*

Remarks of President of Woman's Auxiliary to the AMA

Mrs. Howard Liljestrand, president, Woman's Auxiliary to the American Medical Association, addressed the House. Her remarks were received for information.

Councilor District Caucuses

It was announced that councilor district caucuses would be held Friday morning at 10:30 a.m., with the locations listed on the back page of the *Official Reports Book*. It was noted that a room had been set aside for the specialty delegates in which they could hold a caucus. On Saturday morning further time was reserved at 8:30 a.m. for the second round of district caucuses. Copies of reference committee reports were made available at the caucuses.

Reference Committee Hearings

Reference Committee hearings were held at the following times:

Constitution and Bylaws	3:30 p.m.
Medical Service "B"	3:20 p.m.
Education and Science	3:00 p.m.
Reports of Officers	3:15 p.m.
Medical Service "A"	7:00 p.m.
Governmental Relations	7:00 p.m.
Public Service	7:00 p.m.

Adjournment

The opening session of the House adjourned at 3:05 p.m.

The Second Session of the House, October 11, 1974

The second session of the House was called to order at 1:10 p.m. in the ballroom of the William Penn Hotel, Pittsburgh. John G. Hallisey, M.D., Beaver County, chairman, Committee on Credentials, reported a quorum present.

It was noted that Bradford, Huntingdon, Indiana, Monroe, and Potter counties were without representation in the House of Delegates, as were: Specialty

Societies—Clinical Pathology, Colon and Rectal Surgery, Obstetrics and Gynecology, Pediatrics; SAMA Chapters—Hershey, Jefferson, Temple, University of Pennsylvania.

It was noted that Article VI, Section 3 of the Constitution states that: "If any component society is without any duly accredited voting member of the House of Delegates at any session thereof, then the Active, Senior Active, Intern or Resident member or members registered in attendance from that component society may select himself or one delegate from their number, as the case may be, who shall be the representative of that component society and shall serve in the place of an accredited delegate."

Members of the Society who shall qualify to fill one of the vacancies were instructed to report to the Credentials Committee to apply for the vacancies.

(Secretary's Note: There were no persons present who applied to fill the above vacancies.)

Resolutions 74-20, 74-21, 74-22, 74-23—The Chair announced that in response to an earlier question, a review of the tape recording made of the meeting of Thursday, October 10, showed that resolutions 74-20, 74-21, 74-22, and 74-23 had been properly introduced to become the business of the House. The Chair further noted that this confusion could have been avoided had the resolutions been submitted earlier.

Reference Committee Constitution and Bylaws

R. Robert Tyson, M.D., chairman, presented the following report of the committee:

Allowance for the past Speaker of the House to Speak from the Floor (Pages 14 and 68 of the *Official Reports Book*)

The suggestion that the past speaker of the House of Delegates be added to those other members privileged to speak from the floor of this House was suggested by your speaker, Dr. Lovette. A change in the Constitution has been made by the Committee on Constitution and Bylaws and is presented in the *Official Reports Book*. We heard no adverse comments in the reference committee hearing.

Mr. Speaker, We Recommend approval of this constitutional change.

Change in the Name of the Council on Public Service to Council on Professional Relations and Services (Pages 87 and 93 of the *Official Reports Book*)

Last year, after considerable debate, a Communications Division was approved and has had a year of function. Today there is wholehearted support for this division expressed by all concerned members including the Council on Public Service. The Council on Public Service has recommended that its name be changed to the "Council on Professional Relations and Services." Only favorable testimony was heard in the reference committee hearing.

Mr. Speaker, We Recommend approval of this change in title.

Since the old description in Section 4 (c) of the Bylaws is no longer entirely consistent with the new functions, we recommend the following changes:

Delete: Section 4(c). [The Council on Public Service, which shall be responsible for (i) informing the general public about health, hygiene and the philosophy of organized scientific medicine, (ii) conducting a professional relations program to inform all members of the affairs of organized medicine and to encourage their active participation therein, and (iii) cooperating with organizations concerned with rural health;]
Add: Section 4(c). The Council on Professional Relations and Services, which shall be responsible for professional relations of the Society, including membership recruitment and indoctrination, and the development and administration of programs and services of benefit to members.

Unified Membership (Pages 12 and 66 of the *Official Reports Book* and Speech of A. Reynolds Crane, M.D., president)

Extensive discussion concerning unified membership was heard. However, three times as many spoke in favor of unified membership as spoke against it. The cogent reasons in favor of unified membership included the philosophic concept of a single society rather than fragmented components and the fact that those societies which have unified membership have increased their membership enrollment. An argument against unified membership because of coercion has little meaning when one regards organized medicine as one unit rather than several fragmented units.

Mr. Speaker, We Recommend approval of the Constitution and Bylaws changes as presented in the *Official Reports Book*.

(Secretary's Note: The unified membership amendment failed to win the necessary three-fourths vote.)

Elimination of Delegate Registration Cards (Pages 13, 14 and 68 of the *Official Reports Book*).

The suggestion to eliminate the need for delegate registration cards would simplify the proceedings of the House of Delegates. Having the secretary of each component society certify to the Society the names of the voting delegates and alternate delegates should adequately safeguard the integrity of this House.

Mr. Speaker, We Recommend approval of the Bylaws change indicated in the *Official Reports Book*.

Proposals of the Judicial Council for Disciplinary Proceedings and Appeals (Pages 12, 13 and 67 of the *Official Reports Book*)

Last year this House approved several recommendations of the Judicial Council regarding disciplinary proceedings and appeals. After considerable discussion, the Committee on Constitution and Bylaws carried out their mandate and have presented changes in the Bylaws that would assure that the general public knows of the presence of a grievance committee and the purpose of that committee. They also provide assurances that the grievance will be taken to a higher level if the local grievance committee does not act within a reasonable period of time.

In addition, if any serious offenses are brought to light by the grievance committee, they will be referred to the appropriate board of censors. In the case of a conviction in court for a felony or crime of moral turpitude, automatic suspension is provided. Should there be an appeal to a higher court, the suspension will not be effective until the decision of the highest court of appeal is rendered against the member.

At the time of the suspension, the member has recourse to his local board of censors to appeal the suspension, and provided the suspension is upheld, the member may appeal to the district board of censors in the fashion of any appeal. If the suspension is upheld by the highest board (Judicial Council) to whom appeal has been made, the suspended member, after four months, may request reinstatement by the board of censors and the suspension may be lifted after six months.

We heard considerable testimony concerning the issue of discipline but believe the suggested changes, as originally recommended, represent very importantly the moral duty of the Society concerning discipline and protection of the public. We also feel very strongly that medicine should discipline its own members rather than having the discipline imposed from without.

Mr. Speaker, We Recommend defeat of the alternate Section 9, Chapter XIII, proposed by the Committee on Constitution and Bylaws because of its incompleteness.

Mr. Speaker, We Recommend adoption of the changes in Chapter XIII, Sections 1, 8, 9 and 10 and Chapter XVI, Section 3, as presented in the *Official Reports Book*.

(Secretary's Note: The language prepared by the Committee on Constitution and Bylaws to implement the proposals of the Judicial Council for disciplinary proceedings and appeals was amended by the House of Delegates. The language presented appears on pages 12 and 13 of the Official Reports Book. On page 12, the House determined to delete the sentence reading "The grievance committee shall cause a notice to be published at least annually in a newspaper of general circulation in the county setting forth the purposes of the grievance committee and the manner in which persons may contact it." On page 13, section IX, the House deleted the phrase "which term for the purposes of this Chapter shall include any violation of the federal tax laws or laws relating to health care.")

Alternates to Reference Committees (Pages 14 and 68 of the *Official Reports Book*)

For the past several years, the Speaker of the House of Delegates has appointed an alternate to each reference committee to assure appropriate numbers of representatives on the committee. This has proven to be a very useful change and we propose that it be incorporated in the Bylaws.

Mr. Speaker, We Recommend the Bylaws changes as indicated in Chapter III, Section 9, be adopted.

Election of District Councilors by District (Pages 15, 66 and 67 of the *Official Reports Book*)

This subject has been presented several times and referred back to the Committee on Constitution and Bylaws. The original proposal was that each district elect the district trustee and councilor. In effect, this is what happens at the present time. A district, through its delegates to this House, customarily nominates the district trustee and councilor and commonly there is only one nominee. He is consequently elected. Occasionally there have been other nominees but only from one of the counties involved. In this situation the trustee and councilor is elected by the House of Delegates. In a way this is appropriate, since the trustee, while representing the district, must also represent all members of the Society when he acts as a trustee.

We feel very strongly that no change in the Constitution is necessary to accomplish what already is practice, that is, local nomination and automatic election.

Mr. Speaker, We Recommend defeat of the changes in the Constitution delineated in the *Official Reports Book*.

Changes Requiring at Least Two Candidates be Presented for the Office of Vice Speaker (Page 14 of the *Official Reports Book*)

To meet the policy expressed by this House that more than one nominee be presented for the office of vice speaker, the necessary changes in the Bylaws are presented on page 14. We believe that once a vice speaker has been elected for the first time, an opponent in subsequent years would only be a "straw man" and, consequently, a nominee might be hard to find. Should the House at any time decide that the person holding the office of vice speaker or any other office should be changed, nominations could be made from the floor. We see no reason to change the present Bylaws but also believe that the present change would probably do no significant harm.

Mr. Speaker, We Recommend against the change.

Continuing Education (Pages 15 and 68 of the *Official Reports Book*)

Several times in the past the House of Delegates has strongly reiterated the need for an educational requirement for membership. The changes suggested in the *Official Reports Book* are made at the request of the Board of Trustees and Councilors to be sure that the Constitution and Bylaws are revised to make certain that no member actively providing medical care can avoid the continuing medical education requirement. We found Associate Members are the only group not covered by the present Constitution and Bylaws. Most discussion expressed that the time limit of December 31, 1975, might be too soon.

We feel that the continuing medical education requirement is so important that it should not be delayed for all members, but only for the exceptional few. This can be accomplished by the present appeal system.

Mr. Speaker, We Recommend adoption of the changes in the Constitution and Bylaws as presented.

Changes in Membership Categories (Pages 16, 17 and 68 of the *Official Reports Book)*

The proposal to delete Associate Membership and create a new category of Emeritus Membership was discussed. Most of the evidence seemed to be against this proposal. The proposal could result in a significant loss of dues to the Society.

Mr. Speaker, We Recommend the defeat of the changes in the Constitution and Bylaws as presented in the *Official Reports Book* because there was little support for the proposal as well as the dues loss.

Resolution No. 74-15

Subject: Doctors of Osteopathy being Members of County Medical Societies and not Members of the Pennsylvania Medical Society (Delegates' Packet)

Introduced by: Irving Williams, M.D., in behalf of the Union County Medical Society

Author: J. Preston Hoyle, M.D.

WHEREAS, In many areas of the Commonwealth of Pennsylvania, Doctors of Medicine and Doctors of Osteopathy work side by side; and

WHEREAS, In some areas of the Commonwealth, Doctors of Osteopathy have been accepted as members of hospital medical staffs; and

WHEREAS, Under Medicare, Medicaid, Champus, Pennsylvania Blue Shield, and many, if not all, commercial insurance carriers, a "physician" is defined as a Doctor of Medicine or a Doctor of Osteopathy; therefore be it

RESOLVED, That a Doctor of Osteopathy can become a member of a component county medical society; and be it further

RESOLVED, That if a Doctor of Osteopathy is a member of the Pennsylvania Osteopathic Medical Association that he need not be mandated to join the Pennsylvania Medical Society; and be it further

RESOLVED, That not being a member of the Pennsylvania Medical Society, that he will not, therefore, enter any of the rights and privileges of Pennsylvania Medical Society membership.

Resolution 74-15 requests that osteopathic physicians who belong to the Pennsylvania Osteopathic Society do not need to belong to the Pennsylvania Medical Society when they join a county medical society. This proposal is contrary to our present rules concerning joint membership in the county and state societies. It also is contrary to the idea of unified membership. Furthermore, our present Bylaws draw no distinction between M.D.s and osteopaths and we would be reluctant to create distinctions.

Mr. Speaker, We Recommend the defeat of Resolution 74-15.

Delinquent Dues (Pages 12 and 67 of the *Official Reports Book)*

The suggestion is that the elimination of the delinquent dues requirement for reinstatement in the Society be used as a recruiting aid. We heard suggestions that this might take the form of a one or two-year moratorium only.

We note that loss of membership also will mean loss of benefits such as medical liability insurance or hospitalization insurance. We feel that these losses may be sufficient penalty for the individual in their own right. The loss of these same benefits would probably prevent repetitious failure to pay dues.

Mr. Speaker, We Recommend approval of this Bylaws change as indicated in the *Official Reports Book*.

(Secretary's Note: The House passed a motion that the elimination of delinquent dues should not be a permanent change but only a one-year moratorium to coincide with membership recruitment efforts by the Council on Professional Relations and Services.)

Reference Committee Medical Service "B"

R. Edward Steele, M.D., chairman, presented the following report of the committee:

Mr. Speaker, the reference committee on Medical Service "B" has considered all of the reports, resolutions, recommendations, and actions listed in the Index.

1974 Annual Report, Board of Directors, Pennsylvania Medical Care Foundation (Delegates' Packet) and *Address of Matthew Marshall, Jr., M.D., President of Pennsylvania Medical Care Foundation* (Distributed to House)

The reference committee reviewed the Foundation's Annual Report and believes the Foundation has effectively carried out the directives of the House of Delegates, as approved at the June 1973 Special Session on PSRO and the 1973 Annual Meeting. These actions of

the House directed the Foundation to act as the official organization of the Society responsible for assisting in an advisory capacity in the implementation of the Bennett Amendment in Pennsylvania and to pursue the development of a more desirable and effective utilization review system as an alternative to the Department of Public Welfare's Predischarge Utilization Review Program.

In reviewing the address of the president of the Foundation, the reference committee was impressed with the Foundation's perception of the many problems involved in PSRO and believes the Foundation should continue to assist in seeking solutions based on policies established by the Society and the Foundation.

Mr. Speaker, your Reference Committee recommends that the House of Delegates commend the Foundation for its efforts during the past year and urge the Foundation to continue its efforts to assist in PSRO implementation.

The reference committee also believes that the Foundation should actively pursue development of its other programs and activities. Testimony presented indicated that financial limitations may inhibit pursuit of this objective since the present federal contract does not provide reimbursement for all of the Foundation's activities.

The reference committee has concluded that the House of Delegates should approve the recommendation of the Foundation's president that the Society support the Foundation for clearly assigned responsibilities and activities which may not be reimbursed from other sources.

Mr. Speaker, your Reference Committee recommends that the Foundation be urged to continue other programs and activities that the PMS Board of Trustees determines are essential to the accomplishment of the objectives of the House of Delegates and further recommends that the House of Delegates authorize the PMS Board of Trustees to grant additional funds to the Foundation to carry out these activities within the limitations of the financial resources of the Society, with reports of such actions to be sent to the House of Delegates.

There was not testimony presented on the Foundation board's recommendations on changes to the Foundation's Bylaws and Articles of Incorporation. The reference committee considered the changes to be necessary and appropriate and not substantive in terms of policy.

Mr. Speaker, your Reference Committee recommends that the House of Delegates urge the administrative members of the Foundation to approve the bylaw changes as indicated in Appendix F of the Foundation's Annual Report. (See PENNSYLVANIA MEDICINE, November 1974)

Mr. Speaker, your Reference Committee recommends that the House of Delegates urge the administrative members of the Foundation to approve the following resolution to revise the Articles of Incorporation:

"*RESOLVED,* That Items 8 and 9 be stricken from the Articles of Incorporation of Pennsylvania Medical Care Foundation whereupon Item numbered 10 shall be renumbered Item numbered 8 of said Articles."

Resolution No. 74-1

Subject: Release of Records (*Official Reports Book,* page 97)

Introduced by: Edward N. Moser, M.D. in behalf of the Lycoming County Medical Society

Author: James L. Harrison, M.D.

WHEREAS, Various governmental agencies are continually increasing their scrutiny of the medical care system through the use of ever more sophisticated data processing systems; and

WHEREAS, As a result of this scrutiny, physicians in the private sector will be held to ever stricter bounds of accountability; and

WHEREAS, It is only fair and just that physicians in the private sector be held to no higher standard than governmental agencies; and

WHEREAS, Information on the efficiency and effectiveness of government administered health care institutions is not readily obtainable for purposes of comparison with the private sector; there be it

RESOLVED, That it is the position of the Pennsylvania Medical Society that the standards and regulations which apply to the release of medical statistical information be applied on the same basis for both the public and private sector.

Testimony presented strongly supported the intent of this resolution but recommended a broadening of its scope.

Mr. Speaker, your Reference Committee recommends the adoption of the following substitute Resolution to expand the scope of Resolution 74-1:

"RESOLVED, That it is the position of the Pennsylvania Medical Society that the standards for quality of care, requirements for utilization review, and the regulations for release of statistical medical information be applied on the same basis for both the public and private sector."

Resolution No. 74-2

Subject: Pennsylvania Medical Care Foundation—Avoidance of Conflicts of Interest (*Official Reports Book,* page 97)

Introduced by: F. Peter Kohler, M.D. in behalf of the Delaware County Medical Society

Author: F. Peter Kohler, M.D.

WHEREAS, It is important to eliminate any conflicts of interest at the level of the Board of Trustees of the Pennsylvania Medical Society and the Board of Trustees of the Pennsylvania Medical Care Foundation; therefore be it

RESOLVED, That no trustee, member, or officer of ei-

ther organization shall have any contractual agreement or derive financial benefit or be an executive officer or trustee of an organization or business entity having a contractual relationship or direct business dealings with the Pennsylvania Medical Care Foundation or the Pennsylvania Medical Society.

The reference committee heard extensive testimony on this resolution, most in opposition to its adoption. The testimony presented supporting the resolution did not clearly identify the problem(s) in specific terms which the resolution is intended to prevent.

The reference committee reviewed the action of the 1973 House of Delegates on an identical resolution and received testimony supporting the policy established last year.

The 1973 reference committee reported as follows:

"Testimony supported the intent of Resolution 73-18 as expressed in the "WHEREAS"; however, it was pointed out that the adoption of the "RESOLVED" would unnecessarily restrict the activities of the PMS Board of Trustees and the board of directors of the Foundation since certain members of both boards necessarily serve as directors of other organizations which have contracts or agreements with the Society and/or the Foundation.

"Your reference committee agrees that proper precautions should be taken to avoid possible financial conflicts of interest and that ARTICLE I - GENERAL PROVISIONS AND PROPERTY INTERESTS, *Section 1. Business to be conducted without profit* and *Section 2. Use of income* of the Foundation's bylaws provided the necessary safeguards against financial conflicts of interest."

The 1973 House of Delegates adopted the following policy statement:

"It is the policy of the Pennsylvania Medical Society and the Pennsylvania Medical Care Foundation that members of the respective governing bodies should not vote on matters under consideration if the subject relates to an agreement or contractual relationship between the Society and/or the Foundation and another organization with which the individual board member(s) may be associated."

Mr. Speaker, your Reference Committee recommends rejection of Resolution 74-2 and further recommends reaffirmation of the policy established by the 1973 House of Delegates, as stated above.

Resolution No. 74-23

Subject: Medical Audit and Utilization Review Procedures (Distributed to the House)

Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

WHEREAS, A profusion of methodologies are currently advocated as appropriate for medical staffs to assure quality of care; and

WHEREAS, There is a definite need to assure that methods of review are of appropriate quality, effectiveness, and reasonable cost, relative to the medical care being evaluated, since the time needed for medical audit and utilization review may reduce the time and personnel available for actual patient care; and

WHEREAS, There is little use in devising or promoting elaborate time-consuming protocols for medical staffs to devise criteria or medical audit studies if the medical facts upon which the system is based cannot be readily or accurately determined if the need for medical audit is unlikely or there is no plan for the utilization of the information collected; and

WHEREAS, Techniques for screening, abstracting, and preparing many items of medical review remain in the experimental stage; and

WHEREAS, There is a need to assure that the underlying valid principles of peer review will not be erased by an avalanche of bureaucratic requirements whether developed by governmental bureaucracy or by voluntary agencies to protect physicians; and

WHEREAS, Responsibility for quality of care should be developed primarily at the local level; and

WHEREAS, The current "crisis atmophere" to assure quality of care could lead to regulatory methods that could create an overkill environment less conducive to quality of care; therefore be it

RESOLVED, That the competence of the physician, practicing in an environment conducive to his ability to make judgments and exercise his skills in the best interest of his patients, be recognized as the prime assurance to the public of quality care; and be it further

RESOLVED, That medical audit or utilization protocols which hospital medical staffs are *required* to use for either concurrent or retrospective review for either PSRO, Joint Commission on Accreditation, Medicare, Medicaid, and others, approval be confined to those methods whose screening techniques can be reasonably documented to be valid, reliable, and respectful of the necessity to use both physician and other personnel involved in a cost effective manner; and be it further

RESOLVED, That when such screening techniques show that the medical care in the particular category under review is consistent with the general standard of care for the region, no further professional review should be required and be it further

RESOLVED, That to avoid duplication, when a PSRO, organized by the practicing physicians of the area, has determined that a medical staff has an adequate medical audit and utilization procedure, it should be accepted by the State agency, the Joint Commission on Accreditation, Medicare, Medicaid, and others, unless there is evidence by the state agency or the Joint Commission that the PSRO has not acted objectively; and be it further

RESOLVED, That the Pennsylvania Medical Care Foundation assist the PSROs to assure that methods presented to assist medical staffs are consistent with these recommendations, PSRO requirements and Pennsylvania Medical Society policy; and be it further

RESOLVED, That a similar resolution be introduced in the House of Delegates of the American Medical As-

sociation requesting that the American Medical Association develop standards for reviewing the quality, appropriateness, and cost of the review processes.

Testimony presented strongly supported adoption of this resolution. It was noted for clarification that the last "RESOLVED" is intended to assure that there are appropriate standards or protocols for evaluating the effectiveness and efficiency of present and proposed medical care review processes.

Mr. Speaker, Your Reference Committee recommends adoption of Resolution 74-23.

(Secretary's Note: Resolution 74-23 was amended by the House of Delegates.) The last resolved clause, as amended, reads:

RESOLVED, That a similar resolution be introduced in the House of Delegates of the American Medical Association, requesting that the American Medical Association develop appropriate standards of protocols for evaluating the effectiveness and efficiency of present and proposed medical care review processes."

The resolution was adopted as amended.

Elections

Nominations and/or elections were held Friday afternoon, October 11, 1974. The following officers were elected:

President: A. Reynolds Crane, M.D. (Philadelphia) acceded to the office of president
Vice President: William J. Kelly, M.D. (Allegheny)
Secretary: G. Winfield Yarnall, M.D. (Dauphin)
Speaker: John B. Lovette, M.D. (Cambria)
Vice Speaker: D. Ernest Witt, M.D. (Columbia)

The following trustees and councilors were elected:

First District: Donald R. Cooper, M.D. (Philadelphia)
Sixth District: Joseph M. Stowell, M.D. (Blair)
Tenth District: David W. Clare, M.D. (Allegheny) (To fill the vacancy left by Dr. Kelly's election to vice president)

Three members were elected to serve on the Committee to Nominate Delegates and Alternates to the AMA. They are: Donald E. Harrop, M.D. (Chester) elected to a full three-year term; Charles K. Zug, III, M.D. (Northampton) (to fill the unexpired term of Edgar W. Meiser, M.D., one-year); John G. Hallisey, M.D. (Beaver) (to fill the unexpired term of David W. Clare, M.D. (Allegheny) two years).

Lewis T. Buckman, M.D. (Luzerne) was elected to a second three-year term on the Judicial Council.

The following district censors were elected for a one-year term:

Adams, **James H. Allison;** Allegheny, **William D. Stewart;** Armstrong, **Arthur R. Wilson;** Beaver, **Herman Bush;** Bedford, **James K. Gordon;** Berks, **Brian A. Wummer;** Blair, **John W. Hurst;** Bradford, **Willis A. Redding;** Bucks, **Stanley F. Peters;** Butler, **Robert C. McCorry;** Cambria, **Warren F. White;** Carbon, **James Farr;** Centre, **H. Richard Ishler;** Chester, **Grant W. Bamberger;** Clarion, **Theodore R. Koenig;** Clearfield, **Fred Pease;** Clinton, **George J. Trieres;** Columbia, **James F. Youngkin;** Crawford, **David D. Kirkpatrick, Jr.;** Cumberland, **Hans S. Roe;** Dauphin, **Robert P. Dutlinger;** Delaware, **Richard W. Garlichs;** Elk-Cameron, **Robert J. Dickinson;** Erie, **Robert L. Loeb;** Fayette, **Harold L. Wilt;** Franklin, **Albert W. Freeman;** Greene, **William W. Bartholomew;** Huntingdon, **Thomas R. Mainzer;** Indiana, **John W. Mills;** Jefferson, **Nicholas F. Lorenzo;** Lackawanna, **Louis J. Vitale;** Lancaster, **William A. Schaeffer;** Lawrence, **Gerald H. Weiner;** Lebanon, **C. Ray Bell;** Lehigh, **William F. Boucher;** Luzerne, **Samuel T. Buckman;** Lycoming, **Franklin G. Wade;** McKean, **Bruno P. Sicher;** Mercer, **Frank E. McElree;** Mifflin-Juniata, **Donald E. Basom;** Monroe, **Claus Jordan;** Montgomery, **Rudolph K. Glocker;** Montour, **Robert L. Gatski;** Northampton, **Walter J. Filipek;** Northumberland, **J. Mostyn Davis;** Perry, **James Rumbaugh;** Philadelphia, **Charles M. Thompson;** Potter, **Herman C. Mosch;** Schuylkill, **Joseph T. Marconis;** Somerset, **Alexander Solosko;** Susquehanna, **Raymond C. Davis;** Tioga, **Lane H. Webster;** Union, **Joseph Weightman;** Venango, **Jack E. Torin;** Warren, **D. Jack Furman;** Washington, **Joseph N. McMahan;** Wayne-Pike, **Emil T. Niessen;** Westmoreland, **Leslie S. Pierce;** Wyoming, **John S. Rinehimer, Jr.;** York, **Donald R. Gross.**

(Secretary's Note: It was noted that the Board of Trustees has the power to fill vacancies with regard to district censors.)

Report of the Committee to Nominate Delegates and Alternates to the AMA

The chair introduced the subject of delegates and alternates to the American Medical Association. The recommendations of the Committee to Nominate Delegates and Alternates to the American Medical Association were contained in the Official Call, published on Page 63 of the July 1974 issue of PENNSYLVANIA MEDICINE, on Page 11 of the *Official Reports Book,* and in the 1974 Report of the Committee to Nominate Delegates and Alternates to the American Medical Association, contained in the Delegate's Packet. Elected to two-year terms, beginning January 1, 1975, and expiring December 31, 1976, were:

R. William Alexander, M.D. (Berks County)
Raymond C. Grandon, M.D. (Dauphin County)
Edmund L. Housel, M.D. (Philadelphia County)
William J. Kelly, M.D. (Allegheny County)
William Y. Rial, M.D. (Delaware County)
George A. Rowland, M.D. (Columbia County)

Six alternate delegates were elected for two-year terms, beginning January 1, 1975 and expiring December 31, 1976.

Harry V. Armitage, M.D. (Delaware County)
Robert J. Carroll, M.D. (Allegheny County)
James B. Donaldson, M.D. (Philadelphia County)
Loraine H. Erhard, M.D. (Clearfield County)
Richard L. Huber, M.D. (Lackawanna County)
R. Robert Tyson, M.D. (Philadelphia County)

Elected as alternate delegate to the AMA to fill the unexpired term of David S. Masland, M.D. (Cumberland County) (term began at the close of the House Session and ends December 31, 1975)—H. Robert Davis, M.D. (Cumberland County).

Alternate delegate to fill the unexpired term ending December 31, 1975, created by the elevation of Dr. William J. Kelly to delegate—Lawrence B. Ellis, M.D. (Allegheny County).

Introduction of Resolution

Resolution 74-24

Subject: Approval of Present Methods of Quality Control

Introduced by: John D. Lane, M.D., delegate, Bucks County Medical Society, on behalf of the Second Councilor District

Author: John D. Lane, M.D.

WHEREAS, Present medical practice has ample precedence for quality control mechanisms including tissue committees, mortality conferences and morbidity reviews, medical audit committees, utilization review committees, and continued medical education; and

WHEREAS, These stated mechanisms have the support of grassroots physicians without excessive government interference; therefore be it

RESOLVED, That the above review mechanisms as presently practiced have proven themselves to be superior methods for quality control of medical care; and be it further

RESOLVED, That this resolution be referred to the PMS Delegation to the AMA and be introduced and supported by that delegation at the next business session of the AMA.

(Secretary's Note: Resolution 74-24 was introduced pursuant to Standing Rule No. 2 which specifies that resolutions received after the opening of the House of Delegates must receive a three-fourths affirmative vote to become the business of the House. Such a vote was taken and the resolution was properly introduced. Discussion of the resolution followed and the resolution was adopted as introduced.)

Reference Committee Education and Science

John Y. Templeton, M.D., chairman, presented the following report of the committee:

Mr. Speaker, the Reference Committee on Education and Science has considered all the reports and resolutions listed in the index. Your reference committee has grouped the following items together in a Waiver of Debate list. In each instance there was little or no testimony heard and the committee feels the item is of a noncontroversial nature.

Report of the Committee to Study Relations Between Medicine and Osteopathy (*Official Reports Book,* page 72) (Approve)

Report of the Educational and Scientific Trust (Delegates' Packet) (Approve)

Resolution No. 74-8

Subject: Hypertension (*Official Reports Book,* page 99) (Approve)

Introduced by: Edward J. Resnick, M.D., in behalf of the Philadelphia County Medical Society

Author: John H. Moyer, M.D.

WHEREAS, Hypertension is amenable to treatment once identified; and,

WHEREAS, Many people who are hypertensive are not aware of it; and,

WHEREAS, Every person over the age of thirty-five should be screened annually for hypertension; and,

WHEREAS, Dentists and allied medical personnel can, with proper training, screen for hypertension; and,

WHEREAS, Screening by qualified dentists and allied medical personnel can greatly increase the number of patients who are screened annually for hypertension; and,

WHEREAS, Cooperation between physicians and dentists and allied medical personnel is essential in order to make such screening programs effective, therefore, be it

RESOLVED, That the Pennsylvania Medical Society encourage its member physicians and component societies to interrelate with dentists and allied medical personnel so as to increase the number of patients who are screened annually for hypertension.

Resolution No. 74-13

Subject: Hypertension (Delegates' Packet) (Approve)

Introduced by: John H. Moyer, III, M.D., delegate, Philadelphia County

Author: John H. Moyer, III, M.D.

WHEREAS, The number of patients with hypertension is so great and the benefits of treatment so significant; and

WHEREAS, Screening is essential to discover the large number of symptomless patients; and

WHEREAS, Screening programs have been undertaken by such responsible organizations as the Pennsylvania Department of Health, the Pennsylvania Heart Association, and the Pennsylvania Division of the American Red Cross; and

WHEREAS, The American Medical Association has recommended that patients with diastolic pressures above 90mm be followed and/or treated by a physician; therefore be it

RESOLVED, That persons identified by screening programs as having diastolic pressures above the level recommended by the American Medical Association be referred to a physician or appropriate health care facility.

Mr. Speaker, we recommend that the House take the actions recommended by the Committee on the Waiver of Debate items.

Report of the Council on Education and Science *Official Reports Book*, page 72)

Your reference committee is favorably impressed with the report of the Council on Education and Science and commends its activities during the year. Specifically, the program for the improvement of medical care in Pennsylvania jails and prisons should be continued and additional funds obtained from appropriate sources for expansion. Regarding physicians' assistants, efforts to obtain legislation to legally define their position should be continued. Programs for continuing education of physicians' assistants are desirable and should not be encouraged.

Mr. Speaker, we recommend the adoption of this portion of the Reference Committee report.

Report of the Committee on Aid to Education (*Official Reports Book*, page 65)

Your reference committee approves the report. Recognizing the increasing importance of aid to medical students, the continued allocation of $8 from the annual assessment to the educational fund is endorsed.

Mr. Speaker, we recommend adoption of this portion of the Reference Committee report.

Report of the Committee on Relationships with Allied Professions (*Official Reports Book*, page 70)

Supplemental Report of the Committee on Relationships with Allied Professions (Delegates' Packet)

Your reference committee recommends approval of the report of the committee as printed in the *Official Reports Book*. There was much discussion of the supplemental report and the committee considered this in its two parts.

First, regarding the report of the committee on the recommendations of the Joint Practice Commission, the committee is disappointed that physicians and nurses could not come to mutually acceptable constructive proposals by this time. We are encouraged, however, by the intense interest and dedication evidenced by both groups, urge continued discussions, and believe that a satisfactory resolution of differences can be reached.

Mr. Speaker, we recommend the adoption of this portion of the Reference Committee report.

Second, the committee recommends adoption of that portion of the supplemental report dealing with recommendations and goals of the Pennsylvania Commission on Nursing Education.

Mr. Speaker, we recommend the adoption of this portion of the Reference Committee report.

(Secretary's Note: The adopted recommendations are contained in the supplemental report—Appendix N.)

Resolution No. 74-7

Subject: Nurses to make Determination of Death in Nursing Homes (*Official Reports Book*, page 99)

Introduced by: Robert B. Stuart, M.D., executive secretary, Erie County Medical Society in behalf of the Executive Committee of the Erie County Medical Society

Author: Robert B. Stuart, M.D.

WHEREAS, It is presently a regulation of the Pennsylvania Department of Public Welfare regarding the operation of nursing homes that a physician must personally pronounce a patient dead; and

WHEREAS, It is now a mandatory regulation that nursing homes be adequately covered by skilled care; namely, registered nurses; and

WHEREAS, Nurses have been taught in their training to observe the presence or absence of vital signs; therefore be it

RESOLVED, That in this one instance; namely, residents dying in nursing homes, that the nurse be allowed to make the observation of death and that she communicate by telephone with a physician her findings. If he so concurs with her observations, a death pronouncement will be officially made. The deceased patient will then be allowed to be removed to an appropriate undertaking facility; and be it further

RESOLVED, That the Pennsylvania Medical Society communicate this wish and desire to the appropriate state agencies and the legislature.

It is the opinion of your reference committee that a problem exists in this area of practice. We believe, however, that the solution proposed is undesirable, that it would establish different and unequal standards for the management of a particular group of patients and accordingly would not be in the best interests of the public or the medical profession.

We recommend the rejection of the resolution and offer the following substitute RESOLVED:

RESOLVED, That the House of Delegates recommend to the Department of Public Welfare the reconsideration of present regulations in order to afford relief to the physicians in the areas concerned.

Mr. Speaker, we recommend the adoption of the substitute resolution.

(Secretary's Note: Testimony from the floor favored the original resolved clause and a motion was made and seconded that the original resolved be adopted. A second motion was introduced that the subject be referred to the Council on Governmental Relations and Legal Counsel for further study and development of any necessary legislation. A third motion was introduced and seconded, to amend the resolved clause as originally written to specify that registered nurses be allowed to make determination of death. Inasmuch as the motion to refer takes precedence, a vote was taken on that motion, which passed. The consideration of this topic was thus referred to the Council on Governmental Relations and Legal Counsel for further study and report back.)

Resolution No. 74-9

Subject: Hypertension (*Official Reports Book*, page 99)
Introduced by: Edward J. Resnick, M.D. in behalf of the Philadelphia County Medical Society
Author: John H. Moyer, M.D.

WHEREAS, Hypertension is amenable to treatment once identified; and,

WHEREAS, Many people who are hypertensive are not aware of it; and,

WHEREAS, Every person over the age of thirty-five should be screened annually for hypertension; and,

WHEREAS, For many people the hospital emergency department is their sole contact within a given year with the health care system; and,

WHEREAS, Many people use the emergency department as their primary care physician; therefore, be it

RESOLVED, That blood pressures should be taken of all patients admitted to the emergency department of the hospital unless the patient has had within the year a documented blood pressure reading with the normotensive range.

Your reference committee approves the purpose of this resolution. However, it believes that it should be amended by the deletion of the following portion: "unless the patient has had within the year a documented blood pressure reading within the normotensive range."

Mr. Speaker, we recommend adoption of this resolution as amended.

(Secretary's Note: The author of this resolution introduced an amendment to change the word "hypertension" to the phrase "high blood pressure" throughout the resolution. This amendment was accepted. The resolution was then adopted.)

Resolution No. 74-14

Subject: Beginning of Human Life (Delegates' Packet)
Introduced by: John D. Lane, M.D., delegate, Bucks County Medical Society
Author: John D. Lane, M.D.

WHEREAS, The United States Supreme Court could not determine when human life begins; and

WHEREAS, The sciences of genetics, embryology, and fetology clearly demonstrates that human life begins at fertilization; and

WHEREAS, Organized medicine apparently did not educate the court in the above sciences; therefore be it

RESOLVED, That the Pennsylvania Medical Society inform the United States Supreme Court that it is an accepted biological fact that human life (homo-sapiens) begins at fertilization; and be it further

RESOLVED; That the Pennsylvania Delegation to the House of Delegates of the American Medical Association be instructed to introduce a similar resolution at the next meeting of that body.

Your Reference Committee believes that this resolution is, in fact, peripheral to the matter of abortion legislation upon which this House has already taken a stand. It also believes that the offering of unsolicited advice to the Supreme Court of the United States would be gratuitous.

Mr. Speaker, we recommend the rejection of Resolution No. 74-14.

Resolution No. 74-17

Subject: Reevaluation of PMS Continuing Education Program (Delegates' Packet)
Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society
Author: James R. Dornenburg, M.D.

WHEREAS, The Pennsylvania Medical Society Continuing Medical Education Program includes a mandatory requirement of attaining qualification for the AMA's Physician's Recognition Award, which is currently based upon a three-year continuing education program of 150 hours; and

WHEREAS, This mandatory requirement would unwisely impose a burden upon physicians in various areas of the state where their medical services are essential; and

WHEREAS, The State Board of Medical Education and Licensure has received notification from communities and physicians protesting this situation; and

WHEREAS, The proposed mandatory program could present serious legal difficulties because it would appear to establish a new standard for judging the level of professional competence among physicians; therefore be it

RESOLVED, That the Pennsylvania Medical Society be requested to evaluate the mandatory continuing education requirement, its method of implementation, and its legal implications.

Your reference committee heard much discussion regarding the mandatory requirement for obtaining the AMA's Physician's Recognition Award, read the opinion of Legal Counsel regarding it and agrees that problems exist.

Recognizing this, Mr. Speaker, we recommend the adoption of Resolution No. 74-17.

Mr. Speaker, we offer the following proposals for amelioration of the difficulties identified by your reference committee: (1) There is a six-month discrepancy between the deadline of the qualifying period and the annual processing period of the AMA. We recommend the extension of the December 31, 1975 qualifying period as defined in the Bylaws to June 30, 1976, to coincide with the processing period of the AMA. (2) At present requests for waivers are decided by the Board of Trustees and Councilors on recommendation from the Commission on Accreditation and the Council on Education and Science. Appeals from the decision are returned to the Board. We recommend that requests for waivers go directly to the Commission on Accreditation for its definitive action, with appeal from the decisions of the commission going to the Board of Trustees and Councilors. This arrangement would relieve the Board of routine work and eliminate the present objection that

appeals are decided by the body that made the original decision. (3) We commend the Commission on Accreditation for its efforts in maintaining high standards of patient care and urge that during the difficult initial qualifying period it work to offer all possible assistance to those physicians encountering difficulty in meeting the requirements.

Mr. Speaker, we recommend the adoption of the above three recommendations.

(Secretary's Note: Vigorous discussion of the recommendations followed. On the first point, clarification was requested and given as to the effect of extending the qualifying period to June 30, 1976. Testimony was given to explain that this merely extends the six months processing period for the Physician's Recognition Award to twelve months, and brings it in line with the AMA's qualifying period. This does not give members an additional six months to take courses; course work for the 1975 Physician's Recognition Award must be completed by June 30, 1975. It was properly moved and seconded that the House adopt this recommendation with the idea that it will be referred to the Committee on Constitution and Bylaws for the preparation of appropriate language. This motion carried.

A discussion followed on the second recommendation. The proposal of the reference committee was properly moved, seconded, and adopted.

The third recommendation was then considered. An amendment to the recommendation was properly moved, seconded, and adopted. The recommendation as amended was then voted on and adopted. The amended recommendation as adopted reads:

"We commend the Committee on Accreditation for its efforts in maintaining high standards of patient care and urge that during the difficult, initial, qualifying period, it work to offer all possible assistance, including the device of correspondence courses set up and monitored at the AMA level and to be credited under Category I to those physicians encountering difficulty in meeting the present requirements.")

Resolution No. 74-20

Subject: Confidentiality of Medical Records (Delegates' Packet)

Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society

Author: Michael P. Levis, M.D.

WHEREAS, On 5 June 1974 a contingent of State Police officers raided the Black Action Drug Abuse Center in Pittsburgh and seized about 400 medical records; and

WHEREAS, These medical records were copied and returned to the Center in four days; and

WHEREAS, The Mental Health and Mental Retardation program is an agency of County government; and

WHEREAS, This MH/MR organization has required a detailed 85-item questionnaire on all patients which requested sensitive information; and

WHEREAS, The State Office of Medical Services has required delivery of full copies of both general medical and psychiatric hospital records for determination of eligibility for reimbursement; and

WHEREAS, The State Office of Mental Health has requested a list of the names of all persons in private mental hospitals; and

WHEREAS, The increasing storage and dissemination of sensitive medical information is being controlled by nonmedical personnel; and

WHEREAS, Governmental involvement in accumulation of stored medical information is an invasion of personal privacy; therefore be it

RESOLVED, That the Pennsylvania Medical Society convey its grave concern to the state officials and citizens of the Commonwealth by all available channels regarding the threat to the confidentiality of medical records that we hold inviolate; and be it further

RESOLVED, That action in process on national, state and local levels be pursued actively to insure the protection of individual privacy.

Your reference committee strongly supports the intent of Resolution No. 74-20 but offers the following substitute RESOLVED:

RESOLVED, That the Pennsylvania Medical Society convey its grave concern to the legislature and urge the passage of legislation protecting the confidentiality of medical records.

Mr. Speaker, we recommend the adoption of the substitute resolution.

Introduction of Russell B. Roth, M.D.

Dr. Lovette called the attention of the House to the presence in the House of Russell B. Roth, M.D., immediate past president of the American Medical Association. Dr. Roth was present to receive the Distinguished Service Award of the Pennsylvania Medical Society. Dr. Roth stood and received the applause of the House.

Reference Committee Reports of Officers

David L. Miller, M.D., chairman, presented the following report of the committee:

Mr. Speaker, and members of the House of Delegates, the Reference Committee on Reports of Officers has considered all the items in the index.

Your reference committee has grouped the following items together in a waiver of debate list. In each instance, there was little or no testimony heard and the committee feels the item is of a noncontroversial nature.

Report of the Accountant (*Official Reports Book*, pages 39-42) (File)

Report of the Secretary (*Official Reports Book*, pages 36-37) (File)

Report of Board of Trustees and Councilors (*Official Reports Book*, pages 18-31)

Your reference committee reviewed the entire comprehensive report of the Board of Trustees and Councilors. The following items deserve the attention of the House of Delegates.

The Interspecialty Committee of the Board has recommended disapproval of the income limits proposed by Pennsylvania Blue Shield for Plan C. The Board of Trustees has approved the income limits for Blue Shield Plan C (Supplemental Report A - pages 93-94) and referred the income limits to the House of Delegates for ratification. Your reference committee has been informed that this item has been referred to the Reference Committee on Medical Service "A" for debate and recommendation to the House for action.

The Board has recommended that the 1979 House of Delegates meet at the Hershey Motor Lodge in Hershey, Pennsylvania.

Mr. Speaker, we recommend approval of the plan for the 1979 House of Delegates to meet at the Hershey Motor Lodge in Hershey.

The committee notes that the 1973 House of Delegates asked the Board to study the possibility that all future business meetings of the House be held in the Harrisburg-Lancaster area. We are told that the possibility of this being done is being explored by the Board. Your reference committee heard testimony pro and con as to the advisability of limiting meetings to this area. Problems of availability of rooms for meetings and difficulties with conflicts with other meetings in major cities have been a problem to staff. The executive vice president concurred in the recommendation that the meetings be limited to this area.

Mr. Speaker, your Reference Committee recommends that the report of the Board of Trustees and Councilors be filed.

Report of the Executive Vice President (*Official Reports Book*, pages 32-35)

Your reference committee has reviewed the report of the executive vice president. The committee commends the executive vice president for his aggressive program to provide continued education and stimulation to growth of the staff. The committee is pleased to note that the executive vice president has been on the job in good health in the past year.

Mr. Speaker, we recommend that the report of the Executive Vice President be filed.

Report of the Treasurer (*Official Reports Book*, page 38) and Remarks of Chairman of the Finance Committee

Your reference committee has reviewed the report of the treasurer. We are pleased to note the surplus in the General Fund and the growth of the Medical Benevolence Fund, the Contingency Reserve Fund, and the Property and Equipment Fund.

A question was raised about investment expenses of $1,775. The Finance Committee felt this was money well spent and the explanation satisfied your committee. We are pleased to note the diligence of the Finance Committee in efficiently managing the Society's funds. We noted the remarks of the chairman of the Finance Committee indicating that a dues increase of at least $25 may be necessary, inasmuch as this depends on actions of the House during this session.

Mr. Speaker, we recommend that the report of the Treasurer be filed.

Mr. Speaker, we further recommend that the remarks of the Chairman of the Finance Committee be filed, pending final recommendation to the House of Delegates.

Report of the Committee on Objectives (*Official Reports Book*, pages 69-70)

Your reference committee reviewed the report of the Committee on Objectives. The need for the existence of this committee was questioned in light of the long-range planning activity of the Finance Committee and an ad hoc committee of the Board of Trustees tasked with the responsibility of studying function and accomplishment of these planning committees. We understand that the Board of Trustees is aware of the overlapping responsibility of these committees and will take appropriate action.

Mr. Speaker, we recommend that the report of the Committee on Objectives be filed.

Report of the Pennsylvania Delegation to the AMA House of Delegates (*Official Reports Book*, pages 91-92)

Your reference committee reviewed the report of the Pennsylvania Delegation. The committee notes that of three resolutions presented by our delegation at the December meeting, as mandated by the 1973 House of Delegates one was passed and two were incorporated into the policy of the AMA.

The reference committee questioned the action of the AMA House of Delegates in approving the resolution regarding delineation of staff privileges on the basis that action to implement the intent of the resolution had been taken by the Joint Commission on Accreditation of Hospitals.

The committee congratulates Dr. Russell B. Roth at the termination of his term as president of the AMA; acknowledges the continued service of Dr. William Y. Rial as vice speaker of the AMA House of Delegates; acknowledges the long service of Dr. William A. Limberger and Dr. William B. West as they retire from the Pennsylvania Delegation; and commends the members of the Pennsylvania Delegation for their continued leadership in the AMA.

Your committee is happy to note the "Open Hearings" conducted by the Delegation to the AMA House of Delegates.

Mr. Speaker, we recommend that the report of the Pennsylvania Delegation to the AMA House of Delegates be filed.

Individual Reports from Trustees and Councilors (*Official Reports Book*, pages 43-64)

Your reference committee reviewed the individual reports of the Trustees and Councilors. During our meeting, the need for these reports was questioned, but the consensus seemed to be that they served a valuable purpose. Your committee suggests that because of the length of the reports, money might be saved by mimeographing them and including them in the Delegates' Packets. Due to the length and cost of preparation of these reports, we would suggest that some alternate duplication and presentation to the House be pursued.

Special note was taken of the report of the Trustee and Councilor of the Eleventh District (page 62). The recommendations are: (1) I propose that the Committee on Constitution and Bylaws and the Interspecialty Committee each prepare a draft of model county society bylaws which would specifically reflect the needs of organized hospital and other medical staff groups including provision of a forum for the presentation and resolution of problems of local medical interest. (2) Each county medical society should be encouraged to review its bylaws to determine how its structure might better serve institutional groups within organized medicine.

The purpose of these recommendations is to provide increased communications between hospital staffs and medical societies. His recommendations are endorsed by this committee.

Mr. Speaker, we recommend referral of the recommendations to the Committee on Constitution and Bylaws for implementation.

Supplemental Report A, Board of Trustees and Councilors (*Official Reports Book*, pages 93-94)

Your reference committee reviewed Supplemental Report A of the Board of Trustees. The committee notes the problems inherent in establishing a fixed percentage or quota of physicians to be trained in a particular field of medicine (i.e., Family Practice) and understands that this is merely a recommendation expressing the need and aim for more family practitioners.

Mr. Speaker, your Reference Committee recommends that Supplemental Report A be filed.

Supplemental Report C, Board of Trustees and Councilors (*Official Reports Book*, page 95)

Your reference committee has reviewed the Board's proposal that the House of Delegates approve its plan to include a $10 voluntary contribution for the Benjamin Rush House Restoration Project in the 1975 dues billing.

Your committee heard testimony against this proposal on the basis that it would dilute the effectiveness of PaMPAC joint billing, which we feel has higher priority.

Mr. Speaker, we recommend that this $10 voluntary contribution not be included in the dues billing for 1975.

(Secretary's Note: In response to a question from the floor, the speaker indicated that the Society's Board of Trustees and Councilors continues to investigate alternative means of soliciting a voluntary contribution in support of the Benjamin Rush House restoration project.)

Supplemental Report D, Board of Trustees and Councilors (*Official Reports Book*, pages 95-96)

Your reference committee has reviewed this report asking that the House of Delegates consider the proposal to pay members of the Board of Trustees and others who attend Board meetings a per diem of $50.

Your reference committee heard testimony from trustees that their service as trustees was an honor and was self-rewarding. Other testimony, however, pointed out that the number of meetings can be expected to increase and that a per diem might partially compensate for service.

Mr. Speaker, we recommend approval of a $50 per diem for officers, trustees and chairmen of councils and committees of the PMS who attend Board meetings.

(Secretary's Note: The House of Delegates disagreed with the recommendation of the reference committee, and on vote the recommendation for a $50 per diem failed.)

Supplemental Report F, Board of Trustees and Councilors (*Official Reports Book*, page 96)

Your reference committee concurs with the resolution expressing a sense of loss at the death of Dr. Ralph C. Wilde, adopted by the Board, and recommends that the House of Delegates concur in this action by the Board.

Mr. Speaker, we recommend approval of Supplemental Report F of the Board of Trustees.

Supplemental Report H, Board of Trustees and Councilors (Distributed)

Your reference committee has reviewed Supplemental Report H of the Board of Trustees and Councilors. Your committee heard no testimony in opposition to the recommendation of the Board of Trustees that the 1977 Annual Business Session be changed from Pittsburgh to Lancaster.

Mr. Speaker, we recommend that the 1977 Annual Business Session site be changed from Pittsburgh to Lancaster.

Mr. Speaker, your Committee recommends that the remainder of Supplemental Report H of the Board of Trustees be filed.

Resolution No. 74-4

Subject: Honorary Membership for Walter R. Tkach, M.D. (*Official Reports Book*, page 98)

Introduced by: Jon S. Adler, M.D., secretary, in behalf of the Washington County Medical Society

Author: Jon S. Adler, M.D.

WHEREAS, Walter R. Tkach, M.D., is a native of Pennsylvania and completed his medical education in Pennsylvania and retains an interest in the activities of the Washington County Medical Society and the Pennsylvania Medical Society; and

WHEREAS, Dr. Tkach has held a position of public trust and confidence as personal physician to the President of the United States and has been a credit to the medical profession and to Pennsylvania: and

WHEREAS, The Washington County Medical Society has awarded an honorary membership to Dr. Tkach; and

WHEREAS, Article IV, Section 8, of the Pennsylvania Medical Society's Constitution provides for honorary membership in the Pennsylvania Medical Society, and Dr. Tkach meets the requirements of that section; therefore be it

RESOLVED, That Walter R. Tkach, M.D., be made an honorary member of the Pennsylvania Medical Society.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 74-4.

(Secretary's Note: The House disagreed with the recommendation of the reference committee and did not adopt Resolution 74-4.)

Address of the President (Distributed)

Your committee has reviewed the eloquent, comprehensive address of the president. In considerably less time than his allotted two and one-half hours, Dr. Crane has succeeded in delineating the problems and dangers facing medicine and our patients. We commend him for this address and recommend its wide distribution to our membership for guidance in the coming year.

Mr. Speaker, we recommend that the address of the president be filed.

Announcements

The speaker announced that the last two reference committee reports, Medical Service "A" and Governmental Relations had been passed out and that delegates now had the complete group of reference committee reports.

The speaker announced that the polls would open in the morning at 7:30 a.m. and the House meeting would begin at 9:30 a.m.

In response to a statement from the floor, the speaker determined to refer to the appropriate administrative units those comments of the president concerning the adverse effects of intrusion into patient care by third parties and that the concern of the House over this problem would be relayed to the membership of the Pennsylvania Medical Society.

The House recessed at 5:15 p.m., until the State Dinner in the Pittsburgh Room, scheduled to begin at 8:00 p.m.

The 1974 State Dinner

The invocation was given by the Reverend Dr. John K. Baiz, Rector of the Calvary Episcopal Church of Pittsburgh.

Introduction of Guests

Dr. Sanford began the introduction of guests at 9:35 p.m.: Dr. and Mrs. John B. Lovette, speaker, House of Delegates; Mrs. Howard Liljestrand, president, Woman's Auxiliary AMA; Mrs. Raymond C. Grandon, president PMS Woman's Auxiliary; Dr. Raymond C. Grandon; Dr. and Mrs. Russell B. Roth, recipient, Distinguished Service Award; Dr. and Mrs. A. Reynolds Crane, president, PMS; Dr. and Mrs. Robert S. Sanford, immediate past president, PMS; Dr. and Mrs. Cyrus B. Slease, chairman, Board of Trustees; Dr. and Mrs. David S. Masland, president-elect; Dr. and Mrs. Frederick R. Gilmore, immediate past president, PMS Woman's Auxiliary; Dr. and Mrs. H. Thompson Dale, retiring trustee and councilor;

Also presented were: Dr. Calvin B. Hearne, secretary, Medical Society of Delaware; Dr. Ralph S. Emerson, president elect, Medical Society of the State of New York; Dr. William E. Gilmore, president, West Virginia State Medical Association; Dr. William A. Booth, president, Pennsylvania Dental Association; Mr. George S. Maggio, president, Pennsylvania Pharmaceutical Association; Mrs. Irene Goll, president, American Association of Medical Assistants, Pennsylvania Society; Dr. Vernon C. Buckley, president, Pennsylvania Osteopathic Medical Association; Mr. Milton H. Appleyard, chairman, The Hospital Association of Pennsylvania.

Other guests included Mr. Lester Perry, retired executive director of the Pennsylvania Medical Society; Mrs. Ralph C. Wilde and daughters Diane and Debbie.

Dr. Sanford introduced the following past presidents: Dr. Gilson C. Engel; Dr. and Mrs. Louis W. Jones; Dr. and Mrs. Thomas W. McCreary, Sr.; Dr. and Mrs. Wilbur E. Flannery; Dr. Richard A. Kern; Dr. and Mrs. William B. West; Dr. John H. Harris, Sr.; Dr. George E. Farrar, Jr.,; Dr. and Mrs. William A. Limberger; Dr. and Mrs. George P. Rosemond.

The following past presidents and honorary members of the Woman's Auxiliary were introduced in honor of the Fiftieth Anniversary of the Woman's Auxiliary to the Pennsylvania Medical Society: Mrs. Charles B. Forcey; Mrs. Walter F. Donaldson; Mrs. Paul C. Craig; Mrs. Drury Hinton; Mrs. Albert F. Doyle; Mrs. Frederic H. Steele; Mrs. Willis A. Redding; Mrs. John M. Wagner; Mrs. Alfred W. Crozier; Mrs. Edward P. Dennis; Mrs. Harry W. Buzzerd; Mrs. Malcolm W. Miller; Mrs. Robert F. Beckley; Mrs. Lucian Fronduti; Mrs. Manuel A. Bergnes; Mrs. Axel K. Olsen; Mrs. John A. Schneider; Mrs. LeRoy A. Gehris; Mrs. Ralph S. Blasiole; Mrs. John H. Eves.

Benjamin Rush Awards

Dr. Robert N. Moyers, chairman, Council on Public Service, presented the group Benjamin Rush Award to the Children's Aid Society of Clearfield, Clearfield County. Receiving the award for the Society was Mrs. John G. Soult, Society president. The Children's Aid Society received the award for its record of eight-four years of continuous service to the county. The Society provides emergency care for needy and neglected

children in a home-like atmosphere where children can reside until returned to their homes or placed with foster families.

The individual Benjamin Rush Award was presented to Mrs. Richard Rollins, of Haverford. Mrs. Rollins is a certified Braillist and has given outstanding service in the field of teaching and transcribing standard English braille over the past twenty-three years. In this time she has instructed hundreds of students, many of whom have become certified braillists and accredited instructors. She has also devoted much time to correcting students manuscripts and transcribing textbooks for blind students and books for the Free Library of Philadelphia.

Presentation of Certificate to Retiring Trustee

Dr. Slease presented to Dr. Dale a plaque honoring him for his ten years of service on the Board of Trustees.

Presentation to Woman's Auxiliary in Honor of Golden Anniversary

Dr. Sanford spoke to honor the Woman's Auxiliary on this, its 50th Anniversary. He called on Mrs. Grandon, president of the Woman's Auxiliary to the Pennsylvania Medical Society, and presented to her a check in the amount of $1,000 as a contribution to the Auxiliary's Education Fund from the Pennsylvania Medical Society. Mrs. Grandon expressed her gratitude on behalf of the auxiliary for the gift and for the help given to the auxiliary by the Pennsylvania Medical Society in celebrating its 50th Anniversary.

Presentation of Past President's Medallion

Dr. Sanford presented the past president's medallion and plaque to Mrs. Ralph C. Wilde, in tribute to the great efforts made in behalf of the Pennsylvania Medical Society by the late Dr. Ralph C. Wilde.

Installation and Oath of Office

Dr. Slease, chairman of the Board of Trustees, installed Dr. A. Reynolds Crane, Philadelphia County, as the 125th president of the Pennsylvania Medical Society.

Presentation of Distinguished Service Award

Dr. Crane announced that his first official duty was a happy one, the presentation of the Pennsylvania Medical Society's Distinguished Service Award to Dr. Russell B. Roth, Erie. Dr. Crane drew attention to the fact that this is only the fifth time the award has been presented since its creation in 1955. The presentation of the award is in honor of Dr. Roth's outstanding public and professional activities throughout his medical career. Following presentation of the award, Dr. Roth rose and delivered an impromptu message of thanks to the assembled audience.

Adjournment

The formal portion of the program adjourned at 10:30 p.m. Members and their guests were entertained by Nina Little Productions, Inc., of New York City, and the music of Joe Schafer and his orchestra until 12:00 p.m.

Third Session of the House
October 12, 1974

The third session of the House of Delegates was called to order in the ballroom of the William Penn Hotel, Pittsburgh, Saturday, October 12, 1974, at 9:35 a.m.

The Credentials Committee reported that a quorum was present.

The speaker closed the polls.

Reference Committee Medical Service "A"

Lester A. Dunmire, M.D., chairman, presented the following report of the committee:

Mr. Speaker and members of the House of Delegates: The Reference Committee on Medical Service "A" has considered all of the reports and resolutions listed in the above index. Considerable testimony was received on most of the items listed. However, your reference committee has grouped the following items together in a Waiver of Debate list. In each instance, there was little or no testimony heard and the committee feels the item is of a noncontroversial nature.

Report of the Council on Medical Service (*Official Reports Book*, pages 82-86) (Approve)

Report from Pennsylvania Blue Shield (Delegates Packet) (Approve)

Supplemental Report "B" of the Board of Trustees and Councilors (*Official Reports Book,* page 94) (Approve)

Mr. Speaker, we recommend that the House take the actions recommended by the Committee on the above-listed items on lines 10-17.

Supplemental Report, Pennsylvania Blue Shield (Delegates Packet)

The House will recall that last year Pennsylvania Blue Shield was requested to undertake a study to determine the effects of using a single statewide charge class for Usual, Customary, and Reasonable programs. Your reference committee heard a report by Blue Shield representatives indicating that Blue Shield is continually monitoring this system of fee payment and is willing to work with the Society's Council on Medical Service in the future, as necessary. The Blue Shield report was considered as informational.

Mr. Speaker, your Reference Committee recommends that the Blue Shield Supplemental Report be filed.

Supplemental Report "E" of the Board of Trustees and Councilors (*Official Reports Book,* page 96) and Supplemental Report "G" of the Board of Trustees and Councilors (Delegates Packet)

Your reference committee recognizes that the 1973 House of Delegates approved the concept of Plan C; we also recognize that the return of the questionnaire by members of the House of Delegates indicated that out of a total of 241, 89 physicians were in favor of and 39

physicians opposed Plan C. While it appeared that the mail ballot favored Plan C, your reference committee heard overwhelming testimony in opposition to Plan C with respect to the income levels and the fixed fee concept.

Mr. Speaker, your Reference Committee recommends rejection of the Proposed Blue Shield Plan C as presented in Supplemental Reports "E" and "G" of the Board of Trustees.

(Secretary's Note: Dr. Wilbur E. Flannery offered a substitute resolution which was properly seconded. The resolution reads:

"That the House of Delegates ratify the action of the Board of Trustees of the Pennsylvania Medical Society, accepting the income limits for proposed Blue Shield Plan C of $6,000 for single subscribers and $12,000 for a family subscription."

Discussion on this resolution followed. An amendment was offered to the resolution reading:

"Resolved, That this House reaffirm the concept of the Pennsylvania Blue Shield's proposed Plan C Fee Schedule and directs the Board of Trustees to approve the appropriate income limits provided that this proposal includes a mechanism that will allow for annual adjustment of the premium, the fee paid, and the income limit for service benefits tied to the cost of living.

"Further, it is recommended that such updates be automatic, implemented on a timely basis."

Further discussion on the issue of the proposed Plan C followed. A vote was taken on the amendment, which passed. A vote was then taken on the substitute resolution introduced by Dr. Flannery, which also passed. The final action of the House is as follows:

"BE IT RESOLVED, That the House of Delegates ratify action of the Board of Trustees of the Pennsylvania Medical Society, accepting income limits for proposed Blue Shield Plan C of $6,000 for single subscribers and $12,000 for family subscribers,

"BE IT FURTHER RESOLVED, That this House reconfirm the concept of the Pennsylvania Blue Shield proposed Plan C fee schedule plan and direct the Board of Trustees to approve the appropriate income levels ($6,000 for single subscribers and $12,000 for family subscribers) provided that this proposal include a mechanism that will allow for annual adjustment in the premium, the fees paid, and the income limits for service benefits tied to the cost of living.

FURTHER, it is ***recommended*** *that updates be automatic and implemented on a timely basis.")*

Resolution No. 74-5

Subject: Domiciliary Facilities for Pennsylvania Department of Welfare Patients (*Official Reports Book,* page 98)

Introduced by: F. Peter Kohler, M.D., on behalf of the Board of Directors, Delaware County Medical Society

Author: James W. Dunn, M.D.

WHEREAS, Some hospitals are unable to discharge patients who are on welfare and the Commonwealth of Pennsylvania Welfare Department denies money to cover the over-stay of these patients in hospitals; and

WHEREAS, The Commonwealth has not supplied beds for these types of patients; therefore be it

RESOLVED, That the Pennsylvania Medical Society be alerted to the facts, and also be it

RESOLVED, That since the Commonwealth of Pennsylvania has not supplied domiciliary facilities for these patients, that the Pennsylvania Medical Society urge the Commonwealth of Pennsylvania to provide domiciliary facilities for the Department of Welfare patients.

Hearing no testimony in opposition to this resolution, the committee concurred with its intent. However, it was felt that an additional Resolve should be added to this Resolution as follows:

RESOLVED, That the Commonwealth of Pennsylvania reimburse hospitals for the domiciliary care rendered until an appropriate facility is available.

Mr. Speaker, your Reference Committee recommends that Resolution 74-5 be approved as amended.

Resolution No. 74-10

Subject: Pennsylvania Blue Shield (*Official Reports Book,* page 100)

Introduced by: Edward J. Resnick, M.D. in behalf of the Philadelphia County Medical Society

WHEREAS, The Pennsylvania Blue Shield in its attempt to satisfy the requirements of the Social Security Act Title XVIII, Section 180 has embarked on a program of review which has (1) harrassed the physician in his daily practice, (2) denied reimbursement to the recipient of services, (3) has implied that such services were obtained fraudulently (too many necessary for your condition) and (4) has impugned the integrity of the physician rendering the service—actually defaming character by implication, and

WHEREAS, Though this program is built partially on physician input, it arbitrarily denies reimbursement without proper peer review, and

WHEREAS, Neither patient nor physician has been apprised of these inaccurate and outmoded computerized norms, standards, and criteria, and

WHEREAS, Part B (Blue Shield) without informing the patient or physician that it is a separate entity from Part A (Blue Cross) has discouraged physicians from performing adequate office tests to avoid unnecessary hospitalization; and,

WHEREAS, Blue Shield has refused to pay for necessary laboratory information to properly diagnose patient's illnesses; and,

WHEREAS, Blue Shield has been hiding behind a cloak of anonymity in denying both patient and physician information requested as to the *reasons* for the disposition of their problems; be it

RESOLVED, Blue Shield be coerced, legally, if necessary, to revise its program and reveal to subscriber and physician the norms, standards, and criteria upon which denial of payments are made and the guidelines upon which these are based; be it

RESOLVED, The Pennsylvania Medical Society establish a Blue Shield hotline, the function of which will be to resolve problems and disseminate pertinent information; be it,

RESOLVED, That the Pennsylvania Medical Society immediately set up a program to provide informed legal advice to its members concerning their rights in disputes between them and the Blue Shield and other Medicare intermediaries.

Your reference committee appreciates the intent of Resolution 74-10. However, in view of the testimony presented, and in consideration of the revelation that Blue Shield cannot divulge its norms, standards, and criteria as stated in an HEW Intermediary Letter of December of 1968, the reference committee wishes to make the following substitute Resolution:

WHEREAS, The Pennsylvania Blue Shield in its attempt to satisfy the requirements of the Social Security Act Title XVIII, Section 180, has embarked on a program of review which has (1) interfered with the physician's daily practice, (2) denied reimbursement to the recipient of services, and (3) has implied excessive use of services; and

WHEREAS, Though this program is built partially on physician input, it arbitrarily denies reimbursement without proper peer review; and,

WHEREAS, Neither patient nor physician has been apprised of these computerized norms, standards or criteria; be it

RESOLVED, That Blue Shield be encouraged to revise its program and reveal to subscriber and physician the norms, standards, and criteria upon which denial of payment is made and the guidelines upon which denial is based; and be it also

RESOLVED, That the Pennsylvania Medical Society urge Blue Shield to establish a hotline to Blue Shield, the function of which will be to resolve problems and disseminate pertinent information; and be it also

RESOLVED, That the Pennsylvania Medical Society object to the Intermediary Letter from the Department of Health, Education and Welfare of December, 1968; and be it also

RESOLVED, That the physicians in Pennsylvania contact their Congressmen, asking their assistance in the change of the position of the Department of Health, Education, and Welfare so that the guidelines and criteria can be revealed to physicians.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 74-10 and adoption of the substitute Resolution.

(Secretary's Note: The House amended the second Resolved clause of the substitute resolution as prepared by the reference committee, and adopted a revised third clause.)

The resolution as finally adopted reads:

"*RESOLVED,* That Blue Shield be encouraged to revise its program and reveal to subscriber and physician the norms, standards, and criteria upon which denial is based; and be it also

"*RESOLVED,* That the Pennsylvania Medical Society urge Blue Shield to establish a hot line to Blue Shield and establish our own hot line to the Council on Medical Service, the function of which will be to resolve problems and disseminate pertinent information; and be it also

"*RESOLVED,* That the Pennsylvania Medical Society take such legal steps that are necessary to revoke the intent of the Bureau of Health Insurance intermediary letter #363, December, 1968; and be it further

"*RESOLVED,* That the physicians in Pennsylvania contact their Congressmen asking their assistance in the change of the position of the Department of Health, Education, and Welfare so that the guidelines and criteria can be released to physicians."

Resolution No. 74-11

Subject: Disclosure of "The Nature of Illness" of Patients Hospitalized under the Blue Shield 65 Special Program and Medicare (*Official Reports Book,* page 100)

Introduced by: William A. Rusin, M.D., secretary, Luzerne County Medical Society

Author: Robert M. Kerr M.D., immediate past president, Luzerne County Medical Society

WHEREAS, The recent request for disclosure of "the nature of the illness" of patients hospitalized under the Blue Shield 65 special program may permit release of confidential information on our patients to the federal bureaucracy; and

WHEREAS, It is doubtful that our patients are aware that they have automatically granted such permission in their agreement and application for benefits of this program to Blue Shield and the Medicare bureaucracy; and in view of the recent disclosure that information computer banks of the F.B.I. and other federal agencies have already stored such confidential and personal information on each of us in the United States; and in view of the recent burglary to obtain confidential information from a psychiatrist, Dr. Fielding, concerning his patient, Daniel Ellsberg, by the federal government; therefore, be it

RESOLVED, That the members of the Pennsylvania Medical Society refuse to sign the blanket authorization requested by Blue Shield; and be it further

RESOLVED, That the Pennsylvania Medical Society support the action of the Pennsylvania Medical Society House of Delegates (Oct. 1973), advocating release of only the diagnoses, the medical procedures performed, and the dates involved in any hospitalization; and be it further

RESOLVED, That the Communications Division of the Pennsylvania Medical Society create an information program to alert the public of this infringement on their privacy; and be it further

RESOLVED, That all members of the Pennsylvania Medical Society be urged to discuss this matter with their patients, requesting that they file their objections to this invasion of privacy in order to obtain benefits for which they have paid taxes and insurance premiums: "I hereby rescind the permission I have unknowingly granted to Blue Shield and Medicare to examine any of

my confidential medical records. Any such records may be examined only with the express permission and over the signature of my physician and me or my legal representative."; and be it further

RESOLVED, That the Pennsylvania Medical Society inform the American Medical Association of this action and present a similar resolution at the next meeting of the American Medical Association House of Delegates.

Your reference committee is aware that considerable confusion exists with respect to this matter. However, in view of Blue Shield's explanation at the Reference Committee Hearing, it is felt that it would be appropriate to offer the following substitute Resolution:

RESOLVED, That the Pennsylvania Medical Society urge Blue Shield to send a letter of clarification that the use of the nature of illness card will save the patient and the physician a great deal of time and effort and there is no disclosure of medical data, other than that on the Medicare and Blue Shield forms.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 74-11 and adoption of the substitute Resolution.

Resolution No. 74-12

Subject: DPW Noncooperation with Physicians' Requests for Payment (Delegates' Packet)

Introduced by: David N. Farber, M.D., delegate, in behalf of the Berks County Medical Society

WHEREAS, It has come to our attention that the Department of Public Welfare has repeatedly ignored requests of practitioners to honor bills submitted for services to Medicaid recipients; therefore be it

RESOLVED, That the Pennsylvania Medical Society immediately investigate this intolerable situation and make every effort to rectify it as soon as possible and to see that no repetition of this occurs.

The reference committee is sympathetic with the intent of Resolution 74-12 but believes that the word "continuing" in the Resolve is more appropriate than the word "intolerable."

Your reference committee recommends that Resolution 74-12 be modified as follows:

RESOLVED, That the Pennsylvania Medical Society immediately investigate this continuing situation and make every effort to rectify it as soon as possible and to see that no repetition of this occurs.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 74-12 as amended.

Resolution No. 74-16

Subject: Reaffirmation of the Usual, Customary, and Reasonable Fee Concept (Delegates' Packet)

Introduced by: Joseph V. Caliguiri, M.D., secretary, in behalf of the Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

WHEREAS, Payment for physician services in recent years has been based upon the usual, customary, and reasonable fee concept as implemented by the Pennsylvania Blue Shield, with the approval of the Pennsylvania Medical Society; and

WHEREAS, The UCR concept has proved to be the most workable method of payment in lieu of the difficulties encountered previously with a fixed fee schedule; and

WHEREAS, There is a need to reaffirm the UCR concept by action of the House of Delegates; therefore be it

RESOLVED, That the Pennsylvania Medical Society take action opposing any type of fixed fee schedule and reaffirm the usual, customary, and reasonable fee concept.

Considerable testimony relative to this resolution was included with discussion of several previously-considered items. Your reference committee views this resolution as a restatement of past Society position, but felt it would be appropriate to modify the resolution by including the words "in principle" in the Resolve.

Your reference committee recommends that Resolution 74-16 be modified as follows:

RESOLVED, That the Pennsylvania Medical Society take action opposing, in principle, any type of fixed fee schedule and reaffirm the usual, customary, and reasonable fee concept.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 74-16 as amended.

Resolution No. 74-19

Subject: Obstetrical Fee Coverage (Delegates' Packet)

Introduced by: Henry H. Fetterman, M.D., on behalf of the Pennsylvania Section of the American College of Obstetricians and Gynecologists

WHEREAS, The delivery of quality children should be the goal of the health care of pregnant women, not only those with normal pregnancies but also the high risk pregnancy in the women with diabetes mellitus, hypertension, Rh sensitization or other such complicating diseases, and

WHEREAS, The Pennsylvania Section of the American College of Obstetricians and Gynecologists wishes to affirm its position that fees paid by third party carriers for obstetrical care should be comprehensive fees encompassing both prenatal and postpartum care, as well as the delivery services; therefore be it

RESOLVED, That obstetrical care should no longer be funded partially but rather fully, as are all other types of care; and be it further

RESOLVED, That obstetrical fees no longer be paid by indemnity but by total funding.

The reference committee reviewed Resolution 74-19 and recognized that a portion of what the author requested was not within the jurisdiction of this reference committee or the House of Delegates—namely, that portion of the payment to hospitals for the care of pregnancy and its complications. However, the refer-

ence committee felt that the resolution should be approved, recognizing that the American College of Obstetricians and Gynecologists can be helpful in bringing pressure to bear on insurance companies to cover that portion of the problem.

Your reference committee recommends that Resolution 74-19 be modified by adding the following Resolve:

RESOLVED, The Pennsylvania Medical Society urge the Pennsylvania Insurance Commissioner to require all health insurance carriers operating in the Commonwealth of Pennsylvania to fully cover obstetrical care and fees.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 74-19 as amended.

Resolution No. 74-21

Subject: Recommendation to Blue Shield for a Meaningful Doctors' Plan (Delegates' Packet)

Introduced by: Joseph V. Caliguiri, M.D., Secretary, in behalf of the Allegheny County Medical Society

Author: Jerome Chamovitz, M.D.

WHEREAS, Increasing questions are being raised by the medical profession as to whether Blue Shield is a doctors' plan; and

WHEREAS, Recent changes in Blue Shield policies in the proposed Plan C raise the question whether or not Blue Shield is just another insurance plan; and

WHEREAS, Certain segments of the profession believe that Blue Shield provides inadequate recognition of their services; and

WHEREAS, Certain apprehensions have arisen regarding the recent activities of Blue Shield's Utilization Division with reference to restrictions and limitations of physicians' services and fees; and

WHEREAS, Considerable misunderstanding and lack of knowledge exists on the part of the medical profession regarding Blue Shield policies and also regarding the professional services provided to the participating members due, in part, to Blue Shield's inadequate and ineffective effort to educate the profession; and

WHEREAS, Blue Shield has already established an ombudsman department for its subscribers to educate consumers and protect their interests; therefore be it

RESOLVED, That PMS, through its Council on Medical Service, urge Blue Shield to review its professional relations policy with the council and make recommendations to improve its performance and report suggested recommendations to the House of Delegates in 1975.

There was no testimony presented in opposition to this resolution and Pennsylvania Blue Shield was supportive of the Resolve. Your reference committee believes that Blue Shield and the Pennsylvania Medical Society should strive for better communications.

Mr. Speaker, your Reference Committee recommends approval of Resolution 74-21.

Resolution No. 74-22

Subject: Correction of Inequities Existing between Surgical and Nonsurgical Fees in the Plan C Schedule (Delegates' Packet) and Address of the President (pages 5 and 6) Recommendation Dealing with Alternate Means of Billing (Distributed to the House)

Introduced by: Joseph V. Caliguiri, secretary, in behalf of the Allegheny County Medical Society

Author: Jerome Chamovitz, M.D.

WHEREAS, Blue Shield was organized originally as a surgical plan only, and

WHEREAS, The medical plan was added some years later, with limited coverage and a grossly inadequate fee schedule, and

WHEREAS, subsequent expansion of Plans A and B continued the same limited medical coverage and inadequate fee schedules; and

WHEREAS, these inadequate fee schedules led to inequities between surgical and non-surgical fees; and

WHEREAS, the currently proposed Plan C Fee Schedule perpetuates these inequities; and

WHEREAS, Blue Shield is currently considering an additional increase in the already proposed Plan C Fee Schedule which will only further exaggerate the inequities; therefore be it

RESOLVED, that PMS, through its Council on Medical Service, study the Plan C Fee Schedule to determine the existence of these inequities with the intent of recommending further study of the problem by Blue Shield in an attempt to correct the inequities; and be it further

RESOLVED, that PMS recommend to Blue Shield that no increase in the Plan C Fee Schedule be instituted until a genuine attempt has been made by Blue Shield to correct the inequities.

Since Resolution 74-22 and the recommendation on pages 5 and 6 of the President's Address describe the same subject matter, your reference committee has consolidated these items.

The reference committee heard testimony from a representative of the Council on Medical Service indicating that the council determined not to pursue the matter of alternative billing for physicians' services on the basis that there does not appear to be sufficient sympathy among physicians to warrant such activity and also that such an action could bring the Society into antitrust or restraint of trade litigation.

This recommendation by the Council on Medical Service was subsequently approved by the Board of Trustees.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 74-22 and the recommendation from the President's Address dealing with alternative means of billing.

(Secretary's Note: Discussion of the recommendation followed from the floor of the House. The vote of the House was against the recommendations of the reference committee. Resolution 74-22 and the recommendation in the address of the president were adopted.)

Address of the President (page 6) Recommendation Dealing with Professional Liability No-Fault Risk Insurance Coverage (Distributed to the House)

While the reference committee heard no testimony either in support or in opposition to this item, it felt there was merit in studying this possibility.

Mr. Speaker, your Reference Committee recommends referral of this matter to the Society's Commission on Professional Liability Insurance for study.

Dr. Helwig, of the Society's Council on Medical Service, recommended that through the Reference Committee on Medical Service "A", it be brought to the attention of the House of Delegates that Dr. Sydney E. Sinclair will within the next year retire from Pennsylvania Blue Shield.

Mr. Speaker, your Reference Committee unanimously recommends that the House of Delegates express its appreciation to Dr. Sinclair for his help and dedication throughout many years to the Pennsylvania Medical Society.

(Secretary's Note: Following this recommendation the House broke into applause.)

Reference Committee Governmental Relations

Rex A. Pittenger, M.D., chairman, presented the following report of the committee:

Report of the Council on Governmental Relations (*Official Reports Book*, Page 79)

Mr. Speaker, the reference committee detects a crescendo of governmental activities meriting the attention of the medical profession. The council and staff have been very active in attending to these concerns as reflected in the narrative report.

Resolutions referred by the 1973 House of Delegates were:

73-1: Automatic Notice of Disciplinary Action to the State Board of Medical Education and Licensure

The implementation of this resolution was to be deferred "until such time as legislation can be developed to give physicians legal immunity when making such reports." Senate Bill 1903, introduced September 10, 1974, includes such immunity but is limited to sick physicians. It is the intention of the council to attempt to broaden the coverage and advocate enactment to fulfill the condition specified.

73-2: Opposed the "Comprehensive Health Care Act of 1973". These bills HB987 and SB-863, appear to have been stopped. HB-1710, regarding Certificate of Need, Uniform Accounting, and Licensure of Hospitals has been passed by the House and conforms essentially to the Pennsylvania Medical Society's positions.

73-3: Motorcycle Headlight Requirements

The Senate has passed this legislation and it is pending action in the House.

73-4: Abortion

Intent of second Resolve protecting physicians achieved in Act 78.

73-15: Legislation Protecting Medical Audit Information against disclosure

HB-1729 has been passed and signed into law.

73-23: Education of Family Physicians

The council has continued activity on several fronts. Several bills are in process, both state and federal. The general strategy is to keep up pressure on the Legislature and medical schools, but avoid too agressive coercion.

Mr. Speaker, we recommend reaffirmation of these previous actions of the House.

Supplemental Report of the Council on Governmental Relations (In Delegates' Packets)

In the first three pages the strategy of advocating twenty bills and actively opposing sixteen are reflected.

Worthy of note is the passage of the new Medical Practice Act, Act 190, and the creation of a new Board of Medical Education and Licensure, Act 189. This appears to permit definite improvements including greater authority and flexibility in disciplinary matters. However, there was disappointment expressed in the reference committee hearing in the Legislature's excluding hypnosis from the definition of medicine and expressions of urgency that the council pursue promised legislative action on this issue.

Notable among the opposed bills were those involving the Blue Shield Board and generic equivalents. We were advised that notwithstanding passage of S-570, the Board of Trustees continues to be active with the Attorney General's office and other officials regarding its relevance to medical practice.

The attached listing of the current status of over 100 "bills of interest to medicine" should be reviewed by each member.

Mr. Speaker, the reference committee recommends approval of this Supplementary Report from the Council on Governmental Relations.

Report of the Committee on Discipline (*Official Reports Book*, page 69)

There was considerable discussion relevant to the facts that (1) One set of actions on discipline is before the House (Constitution and ByLaws - "Disciplinary Decisions and Appeals - Subject 3). (2) The State Board of Medical Education and Licensure, active under the new Medical Practice Act, has not yet had time to develop the rules and regulations under which it will operate.

There was consensus that the Pennsylvania Medical Society should be in a position to take the initiative in appropriate disciplinary action and forward same to the State Board. (See Resolution 73-1 above).

It was recommended (1) that the Board of Trustees of the Pennsylvania Medical Society indicate their interest and availability in discussion of the development of rules and regulations and (2) that the Board of Medical Educa-

tion and Licensure be invited to report its progress to the House next year; (3) that action to set up new boards of discipline, either within the Society or government be deferred at this time.

The reference committee supports the position of the Committee on Discipline in *not* reporting disciplinary actions to Blue Shield.

Mr. Speaker, your reference committee recommends approval of this report of the Committee on Discipline which suggests "no further action" at this time.

Resolution No. 74-3

Subject: Hypnosis (*Official Reports Book,* Page 98)
Introduced by: Edward J. Resnick, M.D. in behalf of the Philadelphia County Medical Society
Author: Milton M. Perloff, M.D.

WHEREAS, The House of Delegates of the Pennsylvania Medical Society meeting in Philadelphia, October 1969, adopted a position statement,* which had been prepared by its Commission on Mental Health; and

WHEREAS, It has been established that physicians are referring patients to individuals claiming to be "hypnotherapists" who are neither trained nor licensed to practice medicine, dentistry, or psychology within this Commonwealth; therefore be it

RESOLVED, That the referral of patients to unlicensed individuals utilizing hypnosis for pretreatment and/or treatment of such patients by physicians be considered unethical acts not in the best interest of patients.

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*Text of statement is as follows:

1. *"Hypnosis is a specialized procedure that appropriately could be limited to research, to diagnosis, and to treatment in health care. We recommend that any other use, such as entertainment, should be prohibited by law because the dangers involved in the indiscriminate use of hypnosis may lead to psychoses, economic and personal exploitations, suicidal and homicidal behaviors, physical disorders, and other pathologic conditions of the person.*
2. *"Whoever makes use of hypnotic techniques, therefore, should have sufficient knowledge of psychiatry, and particularly psychodynamics, to avoid its use in clinical situations where it is contraindicated or even dangerous. For hypnosis to be used safely, even for the relief of pain or for sedation, more than a superficial knowledge of the dynamics of human motivation is essential.*
3. *"The teaching of hypnosis should be of sufficient duration and depth for students to acquire understanding of its appropriate place in relation to other treatment modalities. Decisions regarding the depth and extent of the teaching of hypnosis should be made by or in consultation with the appropriate departments of medical schools.*
4. *"Hypnosis for the diagnosis, treatment, and prevention of disease should be used only by physicians licensed to practice medicine who have received adequate training in hypnosis or by persons under the direction of such a physician. Physicians practicing hypnosis should do so only in their particular field of medical competence, except in cases of emergency.*
5. *"We recommend that dentists and psychologists wishing to use hypnosis have adequate training in this treatment modality and should limit its use to their fields of competence. We encourage their respective associations to develop appropriate policies in this regard."*

There was considerable active discussion of the policy of the Society with respect to hypnosis, with some active advocacy of a less restrictive policy permitting the use of lay hypnotist intervention on prescription by a physician for which the physician accepts the responsibility. However, it was pointed out that under such circumstances the hypnotist acts as an independent practitioner and there is no valid basis for assuming competence. It was also emphasized that there are active training programs in hypnosis for licensed professionals and an increasing supply of such persons.

RESOLVED, that the referral by physicians of patients to unlicensed individuals utilizing hypnosis for pretreatment and/or treatment of such patients be considered unethical acts not in the best interest of patients.

Mr. Speaker, your reference committee recommends adoption of substitute Resolution 74-3.

Resolution No. 74-6

Subject: Uniform Donor's Card (*Official Reports Book,* page 99)
Introduced by: Charles Heisterkamp, III, M.D., in behalf of the Lancaster County Medical Society
Author: Charles Heisterkamp, III, M.D.

WHEREAS, There is a considerable need for donor organs; and

WHEREAS, Unfortunately, the largest and best group of donors is that group of young persons killed in traffic accidents; and

WHEREAS, Rapid preservation of tissue is necessary; and

WHEREAS, The one document most frequently immediately available at the time of death is the individual driver's license; therefore be it

RESOLVED, That the Pennsylvania Medical Society actively encourage and support legislation to print the Uniform Donor's Card on the Pennsylvania Operators License.

All discussion was favorable.

Your reference committee recommends adoption of Resolution 74-6.

Supplementary Report I - Board of Trustees

This item provoked vigorous discussion in the reference committee meeting. The reference committee had the impression that there was consensus of approval for the apparent goal of the proposed laboratory regulations (i.e., providing patients with valid, appropriate information about costs.)

The fact was brought to our attention that the Penn-

sylvania Medical Society Board of Trustees supported an essentially similar prepared amendment to the laboratory regulations in 1971. The reference committee acknowledged the fact that there were some risks to occasional doctor/patient relationships and confidentiality, but were not convinced that there were enough on which to base opposition.

The debate was about whether the mechanism of attaching this function by regulation to the Clinical Laboratory Act is legal, and whether this is the most appropriate and/or effective way to achieve this end. Alternate possible mechanisms were referred to, such as (1) requiring physicians to provide, as part of their service, information about costs; (2) Blue Shield proposal to provide coded information or (3) other regulations that might appropriately be involved under the Medical Practice Act.

The reference committee recommends:

(1) That the House approve the inquiry as to statutory authority for this move under the Clinical Laboratory Act;

(2) That the Board continue exploration of alternative methods of achieving the desired ends;

(3) That if the proposed regulation is to be promulgated, the Pennsylvania Medical Society advocate that there be no exclusion, i.e., "hospitals, out-of-state laboratories, etc."

Mr. Speaker, we recommend adoption of this portion of the reference committee report.

Delegate Questionnaire

The chair pointed out that a one-sheet questionnaire was distributed in the House to again get the reaction of delegates to the various changes made in the format of the Annual Meeting.

Reference Committee Public Service

Richard L. Huber, M.D., chairman, presented the following report of the committee:

Mr. Speaker, the Reference Committee on Public Service has considered all of the items listed in the index above.

Report of the Council on Public Service (*Official Reports Book*, page 86)

The council's report is very informative. It was reviewed and found to be detailed and impressive. The reference committee commends the council for its activities in these areas.

Mr. Speaker, the Reference Committee recommends that this report be filed.

The reference committee has grouped the following items together in a waiver of debate list.

Address of the President of the Woman's Auxiliary (Distributed at the House of Delegates); Report, Advisory Committee to the Woman's Auxiliary (page 65); Report, Committee on Medicine and Religion (page 69); Report, Committee on Medical Benevolence (page 71).

The committee feels that the items are of a noncontroversial nature. The committee commends the Woman's Auxiliary and the committees for their efforts.

Mr. Speaker, the Reference Committee recommends that the items listed above be filed for information with the Reference Committee's commendation.

Supplemental Report of the Council on Public Service and Supplemental Report H, Item 2 of the Board of Trustees and Councilors

The reference committee combined the supplemental report of the Council on Public Service and Item 2 of Supplemental Report H of the Board of Trustees and Councilors, as both of these reports concerned the Pennsylvania Medical Cooperative. The committee heard testimony regarding the council's recommendation and on the manner in which the medical cooperative could be implemented at this time. The committee raised questions as to the manner of financing which were answered to the committee's satisfaction by the chairman of the Council on Public Service and representatives of the council.

Mr. Speaker, the Reference Committee recommends adoption of the recommendation in the Supplemental Report of the Council on Public Service and Item 2 in Supplemental Report H of the Board of Trustees and Councilors regarding the Pennsylvania Medical Cooperative.

(Secretary's Note: The supplemental report of the Council on Public Service contains three recommendations: (1) That membership recruitment phase be extended until January 31, 1975 (approximate cost $4,000); (2) That the Pennsylvania Medical Society consider favorably the investment of funds to reach the projected starting capital of $200,000 for the Co-op (maximum of $79,000); and (3) That the council be authorized to begin as early as possible all necessary and appropriate arrangements to make the Cooperative operational within the six-month projected time frame.

Recommendation 2 of Supplemental Report H, Board of Trustees and Councilors reads:

"The Board of Trustees endorses the recommendations contained in the supplemental report of the council."

Considerable debate followed on the three recommendations contained in the supplemental report, which were considered separately. A vote was first taken on recommendation 2, that the Pennsylvania Medical Society consider favorably the investment of funds to reach the projected starting capital of $200,000 for the Co-op (maximum $79,000). After debate on this recommendation, a motion was made and properly seconded that the Pennsylvania Medical Society accrue no further debt in support of the Pennsylvania Medical Cooperative. This motion carried. A vote was then taken on the first and third recommendations of the Council on Public Service. These recommendations passed.)

Delegate Badges

Dr. Witt called the attention of the House to the success of last year's efforts to recycle delegates' badges. He pointed out that a box at the rear of the room had been provided in which delegates should drop their badges as they left.

Annual Assessment

George A. Rowland, M.D., chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report, containing the recommendation of the Finance Committee that the annual assessment for full dues paying members for 1975 be $125.

"Mr. Speaker, members of the House of Delegates, the Finance Committee recommends that the 1975 annual assessment for active members of the Pennsylvania Medical Society be $125.

"Contingent upon the approval by the House of the 1975 assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 6.4 percent of the annual assessment be allocated to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society, which, in the case of full dues paying members will amount to $8.00.

The Finance Committee also plans to recommend to the Board of Trustees that of the annual assessment paid by each active dues paying member, 1.6 percent, or in the case of full dues paying members, $2.00, be allocated to the Medical Benevolence Fund.

This means that rather than $125, a total of $115 of the annual assessment of each full dues-paying member will be available to the General Fund for operating expenses of the Society."

(Secretary's Note: After the recommendation of the Finance Committee was presented, discussion from the Floor of the House favored a more substantial increase in the dues, in order to bolster the Society's communications effort with the public. It was properly moved and seconded that the 1975 annual assessment for Active members of the Pennsylvania Medical Society be $150. This motion carried. Of this sum, 5.33 percent ($8.00) will be allocated to the Educational and Scientific Trust, and 1.33 percent ($2.00) to the Medical Benevolence Fund.)

New Business

Motion: It was moved and seconded that the speaker and vice speaker be congratulated and thanked for the way in which they conducted the meeting. Motion carried.

The House of Delegates was adjourned at 11:45 a.m.

Respectfully submitted,
John B. Lovette, M.D., Speaker
D. Ernest Witt, M.D., Vice Speaker
G. Winfield Yarnall, M.D., Secretary
John C. Rogalski, Assistant Secretary

Appendices

Appendix A

1974 Annual Report of the Pennsylvania Medical Policial Action Committee

Mr. Speaker, members of the House of Delegates, and guests, it is my sincere privilege to present the annual report of the Pennsylvania Medical Political Action Committee.

Perhaps there are some in this august audience who feel this portion of the agenda should be included as part of the necrology report. This feeling may be particularly prevalent at this time after the past two years of scandal which permeated all levels of government including the most powerful and, at one time, prestigious office in the world. If you do feel this way, I ask you to think quite seriously about those national adversities and not simply react to them as aggravating vector forces. Think of them as a medical problem. Use your background of scientific training and diagnostic acumen to analyze these problems. The two are similar. We have all been taught that prevention is the easiest and most economical method to keep the patient disease free.

Now may I present a philosophic point that if disease does occur and it could have been prevented, are we blameless? Be that as it may, at that point in time, we must use therapeutic measures to rid the person of the affliction. These procedures are usually more costly and painful to all concerned than the original preventive procedure would have been. Everyday problems of life are not really a different ballgame. The problems of corruption and misuse of power in elected offices are really a direct corollary. I submit to you, if we do not have a hand in making a careful selection in our candidates for office before the primary election, then whom do we have to blame for a poor candidate in the general election? Why do we hear so many well-educated and influential individuals complain that none of the candidates are satisfactory choices and they won't vote for any of them? Have we not found that the final corrections of the problems created by this type of candidate prove to be costly to everyone in just about every way? Who is really to be blamed for the spoiled porridge? Each of us! Each

of us has an equal responsibility to see that democracy works. This is an inborn prerequisite for a successful government by the people, for the people, and of the people.

Were it not for the increasingly apparent wisdom of our forefathers, who structured our national constitution, we might indeed have fallen from an eminence as a world leader and tumbled to the valleys of oblivion as so many other world powers have done throughout history. But, our method of government has withstood the test of time longer and more effectively than any other attempt man has made in the democratic form of rule.

This should tell us something, something we must always remember if we like our present life style. The democratic form of government will only be viable and effective if we are involved in its system. All of us! Not John and Mary alone, but you and me too. All of us! We must become committed to political action—this includes working in campaigns as well as contributing. It has been said, and wisely so, "The physician truly concerned about patient care is the one who gets involved in the legislative and political arena so that he will have a voice in the matters directly affecting patient care."

I commend to your careful evaluation a document which will be given to you entitled, "My Political Creed." It has been created by the American Medical Political Action Committee and expresses quite well a credo that you may wish to use as a model in formulating your own.

Your Pennsylvania Medical Political Action Committee is a method by which you can direct support to candidates of your choice friendly to medicine in both the national and state legislatures regardless of party affiliations. Your dollars are spent where *you* direct them to be spent. The rest of the PaMPAC dollars are spent in physician education campaign material and organization management. Not one dollar is spent in lobbying.

Recently, political action committees have developed an unsavory connotation. They have been accused of buying congressmen, senators, and presidents. Until all campaigns are federally and state funded, the facts and the law remain that contributions—properly given to candidates—are morally and legally correct. Here are the facts:

1. We're in the Education Business—Physicians and their spouses have historically been involved in the democratic process since the signing of the Declaration of Independence by Benjamin Rush. However, until PaMPAC was formed in 1961, the public never realized how committed the medical family was to good government. They were categorized and maligned as political do-nothings. PaMPAC's educational program is teaching physicians and their spouses how to become politically effective.

2. Where do our Dollars Come From?—PaMPAC accumulates its candidates support fund slowly and painfully in the amounts of $25 for regular membership or $100 for sustaining membership for physicians. Wives may become PaMPAC members for $10 or combined AMPAC-PaMPAC membership for $20. This year the members of the PaMPAC Board voted unanimously to become sustaining members to demonstrate their personal commitment to the concept of the PAC movement. You can identify these sustainers by the 99+ pin they wear. AMPAC and PaMPAC have always based their political funding on the small giver. In fact, this year only five physicians in the United States have given the American Medical Political Action Committee in excess of $100.

3. Policy—Whom do we Support?—The degree of local physician support for a candidate determines whether or not PaMPAC supports the candidate. While other political action committees dictate from their national headquarters, and funds are controlled by a few leaders, PaMPAC relies on the local physicians to direct the campaign spending.

4. Who Writes the Checks?—PaMPAC has a physician treasurer who deposits and disburses political funds under the eyes of the governing board of directors and the federal supervisory officers designated by the Federal Election Campaign Act of 1971. PaMPAC strictly adheres to both the letter and the spirit of the law.

5. Where do you Stand?—The present membership of this House, including the delegates, alternate delegates, and specialty societies, numbers 583, of which 265 are PaMPAC members. This represents a 45 percent commitment, and it is a definite indication that you are already better informed about the PAC than the 28 percent commitment of the general membership statistically reveals. Would I be asking too much if between now and the next annual session that 100 percent of this House become PAC members? The general election is less than one month away. PaMPAC's involvement in this election is directly dependent on local physician involvement and membership dollars. This year PaMPAC's membership is up only 3 percent from that of 1973. We sincerely solicit your most earnest support in this endeavor and will guarantee that the cost of electing responsible, approachable legislators is far less than the cost to attempt to change unfavorable legislation.

In the tradition of American politics, we are providing a slogan for your consideration:

"The person who says that he is above politics is really saying that democracy is beneath him."

Mr. Speaker, I thank this House of Delegates for its attention and continuing support.

Appendix B

Supplemental Report A
Board of Trustees and Councilors

At its August 1974 meeting, the Board of Trustees took action on a number of items which are of interest to the House of Delegates but require no specific action. The Board of Trustees takes this opportunity to inform the House of Delegates of some of the major actions taken at that meeting.

1. Referred back to the Council on Medical Service for further study correspondence from Pennsylvania

Blue Shield on the subject of a prepaid vision care program.

2. Will request the Secretary of Health or his designate to meet with the Board of Trustees of the Pennsylvania Medical Society or appropriate staff to discuss the background and reasoning of the department's multiple health test screening program.

3. Referred to the Council on Education and Science for report back to the October Board meeting the ways and means of getting Category One credit and consideration of means to broaden the ways of receiving this credit.

4. Adopted the recommendation of the Special Committee on Family Medicine that a minimum of 25 percent of each graduating class should be family physicians. The term "family physician" does not include internists, pediatricians, obstetricians, gynecologists, or general surgeons. The Board of Trustees will forward this recommendation to the medical schools in Pennsylvania with the request that their programs be structured so that a minimum of 25 percent of each graduating class will be family physicians. This recommendation will be forwarded to the Legislature and also to the platform committees of both parties.

5. Determined that the Pennsylvania Medical Society will urge the Pennsylvania medical schools to establish family practice departments of equal status with other departments.

6. Determined to support quick expansion for the number of family practice residencies available in Pennsylvania, recognizing that state subsidy will be needed.

7. Determined to request from the State Board of Medical Education and Licensure an opinion as to whether Act 29 (authorizing optometrists to use certain topical drugs in the eye for diagnostic purposes) constitutes the practice of medicine and therefore is in violation of various licensure statutes.

8. Adopted the recommendation that the chairman of the Board should address a letter to the Secretary of Health calling attention to the lack of statutory authority for the inclusion of Section 5.48 of the Clinical Laboratory Regulations and further that such a section can destroy a patient/physician relationship and affect the confidentiality which some patients require. Section 5.48 requires that notice of all charges on tests performed for a patient be sent to the patient by the clinical laboratory unless the patient has been billed directly or otherwise notified. Legal counsel has reported that there is no explicit legislative authority under the Clinical Laboratory Act and the Administrative Code for such a requirement to be promulgated by the Department of Health.

9. Determined to approve, in principle, the resolution of the Pennsylvania Department of Health that currently published JCAH and AOA Hospital Accreditation Criteria Standards and Processes be adopted as basic hospital licensure/approval requirements for all general and special hospitals in Pennsylvania, with the understanding that the Pennsylvania Medical Society will review proposed regulations to implement this resolution before they are adopted.

10. Determined to create an ad hoc committee of the Board with members appointed by the chairman to review the history, composition, activities and accomplishments of the Long Range Planning Committee and the Committee on Objectives which have historically been active in the planning function of the Society.

11. Adopted the recommendation of the Officers' Conference Committee that the 1975 Officers' Conference be held Wednesday, April 23, and Thursday, April 24, at the Host Inn, Harrisburg, to begin at 1:00 p.m. Wednesday, April 23, and conclude at noon, Thursday, April 24.

12. Approved the income limits from Blue Shield Plan C as presented and referred these income limits to the House of Delegates for ratification.

13. Accepted the resignation of Charles E. Schlager, M.D. as secretary and appointed G. Winfield Yarnall, M.D., Harrisburg, to serve as secretary until elections at the 1974 House of Delegates meeting.

14. Approved the request of the Council on Education and Science that the Pennsylvania Medical Society participate in a program to bring about better health care improvement in prisons and jails in Pennsylvania. Funds for this program will be available through the AMA.

Appendix C

Supplemental Report B
Board of Trustees and Councilors

At the 1972 meeting of the House of Delegates, Resolution 72-28, which called for research on physicians' unions and for recommendations to the House on how the objectives of physicians' unions might best be accomplished by the Pennsylvania Medical Society or its component, was referred back to the Board of Trustees for consideration. The Board created the Ad Hoc Committee on Physicians' Unions whose members reported that they felt organized medicine could accomplish all that a union can while avoiding the pitfalls of union activity.

In its supplemental report "B" last year, the Board expressed its approval of the committee's recommendation that no additional Society-sponsored organization was necessary to achieve the objectives of physicians' unions and referred the committee's suggestion concerning the problem of physicians' unions/Society communication to the Long Range Planning Committee.

However, the reference committee referred the resolution back to the Board since it heard testimony that the ad hoc committee's report did not correctly address the resolution. It was specified that the sponsor be present at deliberations on the resolution.

The ad hoc committee met in May and reaffirmed its previous report and re-emphasized that further communications efforts be developed to inform local

members of those actions taken by the Society to protect their rights and to increase the input to the State Society on those problems encountered at the local level.

The Board accepted as information the committee's report at its meeting in August. The minutes of the committee's meeting are attached as Appendix A and are conveyed to the House of Delegates for its review.

Appendix A
Ad Hoc Committee to Study Physicians' Unions
Minutes

The Ad Hoc Committee to Study Physicians' Unions met at 9:35 a.m., Wednesday, May 15, 1974. Committee members present were: Donald R. Cooper, M.D.; Kenneth L. Cooper, M.D.; David J. Keck, M.D.; Leroy A. Gehris, M.D. and Ralph K. Shields, M.D., chairman of the committee. Also present were: Robert F. Beckley, M.D., present to discuss Resolution 72-28 and John C. Rogalski, acting as secretary.

The meeting began with a review of the resolution and the previous report presented to the House of Delegates by the Ad Hoc Committee to Study Physicians' Unions. Following this review, Dr. Beckley spoke to present his view that the report of the committee did not answer the intent of the resolution. Dr. Beckley's concern is that organized medicine develop ways of dealing with those problems confronting physicians which lead physicians to join unions. Dr. Beckley described the need to fight those pressures forcing physicians into salaried positions. He explained his view that individuals can object to these pressures but there is no organized body acting in their support. Dr. Beckley expressed his fear that unions will negotiate away the traditional ethical principles of medicine.

Discussion then centered on whether there was anything within the scope of physicians' unions which could not be done by organized medicine and the record of organized medicine in accomplishing those things which unions claim they will accomplish. Several members of the committee expressed the view that there appeared to be nothing within the reach of union activity which could not be discharged by organized medicine, as currently structured. In this connection, the committee sought to find what particular tool a union has to enforce its demands that organized medicine does not command. Except for a strike no such mechanism for action could be identified. The committee realized that members may not be fully cognizant of what actions the Society is currently undertaking. An increase in communications efforts, as pointed out in the previous report of the committee, may be a solution to this problem.

The committee discussed the necessity for some way to bring more weight to bear at the local level. In this connection the committee noted that the medical society is a professional organization, representing the most highly regarded of the professions and thus does not have open to it some of the options available to workers in other fields. Since most of the problems creating pressures to unionize are political, not personal, the committee felt there is a need for a method through which members with a complaint can get an advocate. In order to mobilize the Society's energies on behalf of individual members, it was suggested that an action line for complaints and requests be set up. The suggestion was modified by the consideration of having all such requests go through an official arm of the local county society and in this way screen out any possible disagreement at the local level.

In summary, the Ad Hoc Committee to Study Physicians' Unions reaffirmed its previous report reemphasizing the recommendation that further communications efforts be developed both to inform local members of those actions taken by the Society to protect their rights and to increase the input to the State Society of those problems encountered at the local level.

Appendix D

Supplemental Report C
Board of Trustees and Councilors

In August, the Board decided to endorse the efforts of the Benjamin Rush House Committee by including on the next dues billing a $10 voluntary contribution to that committee. This endorsement came at the request of Dr. Robert E. Jones, chairman of the committee, who requested that the Pennsylvania Medical Society participate in its American Bicentennial project to restore the Philadelphia birthplace of Benjamin Rush, a signer of the Declaration of Independence and the "Father of American Medicine."

A bill is presently in the Senate (H.B. 327) to create a Benjamin Rush State Park utilizing 272 acres of grounds of the Philadelphia State Hospital. Funds for restoring the house, which was accidentally razed in 1969 and is to be relocated on those grounds, must come from private sources, according to Dr. Jones.

The American Psychiatric Society approved a similar resolution providing for a $10 voluntary contribution to be included in its members' annual dues billings.

The Board has asked the Pennsylvania Delegation to the AMA to introduce a resolution calling on the AMA to support the Benjamin Rush House Committee in a similar way.

The Board members feel it would be appropriate for members of the Pennsylvania Medical Society to participate in the Bicentennial in this fashion and, accordingly, **asks the House of Delegates for approval of its plan to include a $10 voluntary contribution in the 1975 dues billing.**

Appendix E

Supplemental Report D
Board of Trustees and Councilors

In August, the Board of Trustees considered the question of whether those members who attend meetings of the Board of Trustees should receive a per diem

of $50. After considerable discussion, it was felt that they should, but that the matter should be referred to the House of Delegates for final disposition.

Members of the Board attend six Board meetings per year in addition to councilor district meetings and county society meetings which take considerable time away from their practices. In addition, meetings take considerable preparation beforehand. The agendas are long and complex.

Because of this, some members of the Society may feel that they can afford neither the time nor the resultant loss of income to serve as members of the Board of Trustees. A per diem would partially reduce the expense to those members who are willing to serve.

Some state medical societies do provide this kind of remuneration to their trustees for the time they spend in attending Board and other required meetings. Officers and Board members of the California, Illinois, and Texas medical societies receive a per diem (plus expenses).

We believe the per diem is a fair means of recognizing the time involved in doing a good job. It would probably increase the number of those who are willing to serve, giving Society members a greater selection of potential decision-makers and leaders.

Eventually, no doubt, the Society will want to apply the same question to other units such as councils and committees and peer review bodies. The costs could be considerable. But the logical place to begin consideration would seem to be with the Board of Trustees.

The Board of Trustees respectfully requests consideration by the House of Delegates on the proposal to pay members of the Board of Trustees and others who attend Board meetings a per diem of $50.

Fiscal Note: The cost for this is estimated at $10,800 annually.

Appendix F

Supplemental Report E
Board of Trustees and Councilors

In the Annual Report of the Board of Trustees (under the subtitle "Proposed Plan C") we reported that, in accordance with House action, the Interspecialty Committee was being balloted for its recommendation concerning Blue Shield's proposed Plan C income limits of $6,000 for individuals and $12,000 for families. By a one vote margin, the committee decided to recommend that the Board of Trustees reject the proposed income limits. The committee so recommended through its chairman, Robert S. Pressman, M.D., at the meeting of the Board of Trustees on August 14, 1974.

However, after weighing all the factors, the Board of Trustees determined to approve the income limits. The Board's reasons for doing this are explained in my letter in late August to members of the House through which the Board sought ratification of its action, as stipulated by the 1973 House of Delegates.

At this writing no results are available on the ratification survey. You recall that the Bylaws of Blue Shield empower the Board of Trustees of the Pennsylvania Medical Society to approve income limits for any newly proposed Blue Shield fee schedule plan. Obviously if the House, in the mail survey, shows a strong disapproval of the Board's action, the Board of Trustees will review its position and report any change to you at the Annual Session.

Appendix G

Supplemental Report F
Board of Trustees and Councilors

At its meeting on August 14, 1974, the Board of Trustees adopted a resolution expressing its sense of grievous loss at the death of Ralph C. Wilde, M.D., president of the Pennsylvania Medical Society. Dr. Wilde was highly respected by all members of the Board. He was a valued leader, a man of great personal integrity, and a warm-hearted good friend. All our lives have been darkened a little at his passing.

A copy of the Board's resolution appears as Appendix A.

Appendix A
MEMORIAL RESOLUTION
Ralph C. Wilde, M.D.

WHEREAS, On July 10, 1974, Almighty God called from among us our esteemed President and honored colleague, Ralph C. Wilde, M.D.; and

WHEREAS, Dr. Wilde will be remembered for his dedication not only to his patients and students, but also to the highest principles of the profession; and

WHEREAS, His courage to carry on his duties to the Society and the other humanitarian activities he supported in spite of his serious illness have provided a model to us all; and

WHEREAS, His work as clinical assistant professor of surgery at the University of Pittsburgh Medical School, his surgical skills at Pittsburgh hospitals, his past presidency of the Allegheny County Medical Society, and his contributions to medical literature exemplify lasting leadership; therefore be it

RESOLVED, That his death be proclaimed a great loss to the Pennsylvania Medical Society, to his own city of Pittsburgh, and most especially to his family; and be it further

RESOLVED, That the Board of Trustees and Councilors record its deep appreciation for Dr. Wilde's life and work, its profound sorrow in his passing, and its deep sympathy to Mrs. Wilde and his daughters; and be it further

RESOLVED, That this action be recorded in the minutes of the Board of Trustees and Councilors and that a copy thereof be presented to his family.

Appendix H

Supplemental Report
Second District

During the Second Councilor District breakfast on Thursday morning, April 25 at Officers' Conference, a question was raised regarding the seating arrangement at the House of Delegates session.

Specifically, the Second Councilor District went on record in the form of an approved motion, that the executive secretaries of county medical societies be allowed to sit with their delegations during each session of the Pennsylvania Medical Society House of Delegates. This action was taken because, when assigned seating was initiated in the House as mandated by a 1972 House action, executive secretaries were prohibited from sitting with their delegations. The counties of the Second Councilor District are strongly of the opinion that the executive secretary is of vital importance to them in arriving at decisions in the House.

Attached as Appendix A is a copy of a letter from F. Peter Kohler, M.D., secretary, Delaware County Medical Society, to John B. Lovette, M.D., speaker of the House, dated November 13, 1973, reporting on an action on this matter taken by the board of directors of the Delaware County Medical Society.

Appendix A

John B. Lovette, M.D.
Speaker, House of Delegates

Dear Dr. Lovette:

I have been requested by the board of directors to inform you that the Delaware County Medical Society feels that a different plan of seating should be operative at the next session whereby the executive secretary may sit with the delegates from the Delaware County Medical Society to the Pennsylvania Medical Society House of Delegates meeting.

Kindly acknowledge receipt of this letter at your earliest convenience.

Appendix I

Supplemental Report G
Board of Trustees and Councilors
(Referred to Reference Committee on Medical Service "A")

In Supplemental Report E of the Board of Trustees and Councilors, we reported that the ratification survey of the Board's action with respect to proposed Plan C income limits was under way but no results were available. At the time of preparation of this report (September 30, 1974), we have heard from 125 members of the House of Delegates, eighty-eight of whom approve the Board's endorsement of the proposed income limits, thirty-five who disapprove and two expressed no opinion.

In view of the slow return of the survey forms by delegates, and in view of the fact that the meeting of the House of Delegates is so close at hand, the Board of Trustees has determined to refer the subject of the Board's endorsement of the Plan C income limits directly to the House of Delegates through the medium of this supplemental report.

It is the Board's belief that when the House took its original action for ratification of the Board's action, the House anticipated the delegate survey would take place much earlier in the year. Although the Board of Trustees has implemented the action of the House to the letter, the Board now concludes that it would be inappropriate to regard the ratification survey as conclusive at this point in time. It is convinced that the issue of Plan C income limits requires the kind of colloquy and debate which is available only thorugh reference committee hearings.

Appendix J

Supplemental Report H
Board of Trustees and Councilors
(Referred to Reference Committee on Reports of Officers with the exception of item 2 re Pennsylvania Medical Cooperative which is referred to Reference Committee on Public Service)

On October 9, 1974, the Board of Trustees met to consider various items of business. The following matters either require action by the House of Delegates or are of special interest:

1. The Board of Trustees received a report from staff relating the difficulties encountered in working with the management of the William Penn Hotel in connection with the 1974 Annual Business Session. Staff reported similar difficulties in dealing with the Pittsburgh Hilton in 1971. The Board also noted the action taken by the House of Delegates last year which called for the Annual Business Session to be held in the Harrisburg-Lancaster area, if possible, after 1978. **Accordingly, in view of these difficulties and in light of this policy of the House, the Board of Trustees recommends that the site of the 1977 Annual Business Session be changed from Pittsburgh to Lancaster.**

2. The Board of Trustees reviewed a report from the Council on Public Service concerning the status of the recruitment campaign for the Pennsylvania Medical Cooperative. It noted that over 1,200 members of the Society had become charter members and that this, in fact, represented over 2,000 physicians, since many of the subscribers represented group practices. In its supplemental report to the House, the Council on Public Service is asking the Society to guarantee the recommended base line capitalization for the Cooperative if sufficient capitalization isn't achieved through an extended recruitment program. The council also is recommending that the Cooperative begin as early as possible to become operational within six months. **The Board of Trustees endorses the recommendations contained in the supplemental report of the Council.**

The following items are for the information of the House:

1. Tentatively approved the 1975 budget which projects a deficit of $203,728.

2. Determined to forward to the AMA Delegation a resolution for introduction into the AMA House of Delegates asking for a review of AMA quackery activities to determine if the intent of already established policy to increase these activities are, in fact, being carried out.

3. Referred to the Council on Governmental Relations the responsibility for developing recommendations concerning physicians who testify in malpractice suits outside of their recognized specialty or for apparent financial gain rather than in the public interest.

4. Directed the Council on Governmental Relations to explore the possibility of drafting legislation which would require Pennsylvania to move to a binding and compulsory medical malpractice screening plan.

5. Authorized the president to appoint a committee broadly representative of various medical specialties to meet with the insurance commissioner concerning the department's position paper against direct billing by hospital-based physicians.

6. Determined to communicate with HEW Secretary Caspar Weinberger indicating the Society's displeasure with his statement alleging unreasonable escalation of physicians' fees and recommending that any future comparisons by the secretary be based on pre-freeze costs, utilizing the All Services Component of the Consumer Price Index as a more valid and objective measure of comparison.

7. Approved for offering to the membership the basic and major excess medical coverages underwritten by the Insurance Company of North America which would be substituted for the existing PMS-endorsed basic major hospital expense plan and excess major medical plan. Also approved the hospital indemnity plan underwritten by the Continental Insurance Company.

8. Endorsed the uniform health insurance claim form for use by all Pennsylvania third party payers. Directed the Council on Governmental Relations to make recommendations concerning the introduction of legislation which would make compulsory in Pennsylvania the use of the uniform claim form.

Appendix K

Supplemental Report I
Board of Trustees and Councilors
(Referred to Reference Committee on Governmental Relations)

At its August 14 meeting, the Board of Trustees discussed in detail a proposed regulation under the Clinical Laboratory Act promulgated by the Department of Health which would require disclosure by the laboratories (except hospital and out-of-state laboratories) to the patients of the laboratory, the fee paid by the physician for the test(s) performed by the laboratory. The Board of Trustees passed the following motion:

"It was moved and seconded that the President should address a letter to the Secretary of Health calling attention to the lack of statutory authority for the inclusion of Section 5.48, and, further, that such a section can destroy a physician/patient relationship and affect the confidentiality which some patients require."

Subsequently, on two (2) separate occasions, one of which was held in the governor's office, representatives of the Society met with Health Department officials to discuss this matter and to emphasize additional concern regarding the totality of the regulations and to request a moratorium on the implementation of the proposed regulations.

The Board of Trustees reaffirmed its position at their October 9 meeting and is requesting the House of Delegates to support their position in this matter and to urge continued negotiations with the Department of Health so that this problem can be resolved.

Appendix L

Supplemental Report
Council on Governmental Relations
(Referred to the Reference Committee on Governmental Relations)

As we promised in our annual report, which appears in the *Official Reports Book*, we herewith submit a supplemental report on state legislation of interest to the Medical Society, as of the middle of September. This two-year session of the General Assembly comes to an end finally on November 30, so that all bills not acted upon by that time expire with the final adjournment and must be reintroduced at the time of the next session which starts in January, 1975.

Attached to this report is the list of over 100 measures which the Council on Governmental Relations has been entrusted with during the last two years of the 1973-74 session of the Pennsylvania General Assembly.

At the last meeting of the Board of Trustees in August, the council reported on twenty measures which the council recognized as having top priority with the Society for passage at this session. Here, in capsule form, is a report on the position of these measures.

(1) H-759 and H-760—The amendments to the Medical Practice Act and the creation of a new Board of Medical Education and Licensure have passed the Legislature and have been signed by the governor as Act 189 and Act 190.

(2) H-1729—The measure to protect physicians serving on PSRO and other committees and their data has passed the Legislature and has been signed by the governor as Act 193.

(3) H-1363, H-1364, and H-1365—The so-called "Immunization Package": the first two bills permit the Advisory Health Board to make rules and regulations concerning immunization schedules and eliminate the necessity to go back to the Legislature each time new immunization schedules are needed were signed earlier this year as Acts 67 and 68. H-1365, the remaining measure, to protect physicians and nurses participating in mass immunization programs not for profit and approved by the state, has been approved by the House and Senate and has been sent to the governor for his signature. *(Subsequently signed into law.)*

(4) H-1639—The measure to create a psychotherapist/patient privilege has passed the House and is currently on the Senate's calendar.

(5) H-1468 and H-1469—The measures to permit the State Board of Medical Education and Licensure to regulate and certify physicians' assistants have passed the House, and we have been promised action in the Senate prior to adjournment. They are now vital, since Section 4 of H-760 was removed by the Senate as being too broad and not sufficiently specific.

(6) S-443—The measure to protect physicians not wishing to participate in abortion procedures, and protecting those that do from discrimination, has passed the Legislature and has been signed by the governor as Act No. 78.

(7) Reorganization Plan No. 2—To transfer the supervision of general and special hospitals to the Department of Health, of course, was passed earlier this year. The supervision for hospitals is now housed in the Health Department.

(8) H-2314—Would permit the State Board of Medical Education and Licensure to regulate the practice of acupuncture. It was only introduced recently, and sufficient time may not be available for its action at this session. The opinion of the Attorney General, limiting the use of acupuncture to physicians, dentists, and podiatrists will at least stop the use by chiropractors and others until the legislation can be reintroduced at the next session.

(9) H-2054—The measure to tighten up drug prescribing has passed the House and is before the Senate where we have been promised early consideration.

(10) H-1550—The measure to have medical schools affiliate with community hospitals and be responsible for rural areas, etc., was the subject of hearings at which the Society testified, and we have been promised action on this measure this session.

(11) The so-called "ambulance package"—S-67, S-68 and S-69, have all passed the Senate and are before various committees in the House.

(12) H-1040, the measure to restrict the use of hypnosis to physicians, dentists, and psychologists has been permanently recommitted to the committee in the House.

(13) H-10—The measure to require water companies to fluoridate their water supplies was defeated twice on the Floor of the House of Representatives.

(14) S-757—The measure to require motorcycles to have their lights on at all times has passed the Senate and is before the House Transportation Committee.

In the category of those measures that the council opposed vigorously, there are sixteen. These seemed to occupy a great deal of our time:

(1) H-139, S-151, and S-733—These measures would remove the requirement that a majority of board members of Blue Shield be physicians. All of these measures remain in their original committees.

(2) S-1192—Requires health insurance companies to pay all members of "healing arts" equally. This was defeated 29 to 17 in the Senate.

(3) H-652 and H-653—Would permit pharmacists to substitute generic equivalents. These bills remain in committee.

(4) H-987 and S-863—These bills are the governor's Comprehensive Health Care proposals. They remain in their original committees.

(5) H-792—Permits generic prescribing for Welfare patients. This, too, remains in committee.

(6) S-570—Permits optometrists with additional training to use certain drugs. Passed and signed by the governor.

(7) H-888—Would require prescriptions to be written on check-type paper in triplicate. This measure remains in its original committee.

(8) S-854—Would permit the State Board of Optometric Examiners to license opticians—This bill remains in Senate committee.

(9) S-1023—Would require repayment of tuition paid to medical colleges on behalf of students. Remains in committee.

(10) H-712—Would make it absolutely illegal to terminate any abortion. This bill remains in committee.

(11) H-803 and S-36—Would add two and four consumers to all state professional and occupational licensing boards. Both remain in their respective committees.

All other bills on the attached list received appropriate response as the necessity indicated, but the above listed measures occupied most of our time.

Legislation of Interest to Medicine Introduced into the 1973-74 Session of the Pennsylvania General Assembly As of September 1974

Bill No.	Explanation	Society's Position	Legislative Position
	Abortion		
S-443	Excuses hospitals and physicians from performing abortions	Support	Passed; Act No. 78 of 1973
H-712	Illegal to terminate certain pregnancies	Oppose	Referred to Law and Justice Committee

Bill No.	Explanation	Society's Position	Legislative Position
H-818	Offenses defined for committing abortions	Oppose	Referred to Committee on State Government
H-923	Restricts use of state money for abortions	Oppose	Debated in House; recommitted to Committee on Health and Welfare
S-1318	Written informed consent in emergencies	Legal comments forwarded	Passed Legislature; vetoed by governor—veto overridden
S-1337 H-1926	Regulate commercial abortion services	No position	In Senate Committee on Public Health and Welfare
H-1830	Prohibits payment of fees to commercial abortion referral agencies	No position	In House Committee on Law and Justice
	Acupuncture		
H-2314	Gives State Medical Board authority to regulate	Support	In House Professional Licensure Committee
	Ambulances		
S-67 S-68 S-69 H-887	Upgrade state ambulance services; require operators to have certain basic education and licensure by the Pennsylvania Dept. of Health	Support	Bills have passed Senate; S-67 in House Committee on Professional Licensure; S-68 on House table; S-69 passed House
	Anatomical Gifts		
H-2474	Permits appropriate markings on drivers' licenses to indicate a donor	Support	In House Committee on Transportation
	Audiologists		
S-1799	Separate Board to license audiologists	Oppose	In Senate State Government Committee
	Blood		
H-1864	Consent age for donors reduced to 17	Support	Defeated in House
H-2254	$5.00 Income tax credit for pint donation	Support with amendments	In House Health and Welfare Committee
	Blue Shield		
H-139 S-151 S-733	Remove provision from Blue Shield Act that requires a majority of directors to be physicians	Oppose	All remain in Committee
	Child Health		
H-767	Requires a course in VD education in high schools	Support	Passed House; in Senate Committee on Education
S-1166 H-1603	New "Battered Child" Law	Support	Each chamber has passed its own bill

Bill No.	Explanation	Society's Position	Legislative Position
	Chiropractic		
H-630 S-1028	Further prescribing disciplinary powers of Chiropractic Board	No action	House bill referred to Consumer Protection Committee; Senate Bill in Committee on State Gov't
H-2472	Gives Chiropractic Licensing Board authority over advertising	No position	Passed House—before Senate Committee on Rules
S-1192	Requires health insurance companies doing business with state to pay "healing arts" equally	Oppose	Defeated in Senate; vote was 29-17
H-1360	No "practitioner of the healing arts" may use x-ray unless graduated from an "accredited" school	Support	In House Committee on Health and Welfare
H-1361	No "healing arts" practitioner to be licensed in Pennsylvania unless graduated from an "accredited" school	Support	In House Committee on Health and Welfare
H-2126	Amends definition to exclude acupuncture	No position	In House Professional Licensure Committee
	Confidentiality		
H-1639	Creates confidentiality between psychotherapist and patient	Support	Passed House; on Senate calendar
H-2192	Regulates personal data systems	Support in principle	In House Consumer Protection Committee
	Coroner		
S-348 S-349	Coroner to be appointed by County Commissioners	Oppose	Referred to Committee on Local Government
	Drugs		
H-289	School or family physician to give urine test to students believed to be using drugs	Support	In House Committee on Education
S-45	Amends "Controlled Substance, Drug, Device and Cosmetic Act" to add an additional prohibited act—"The dispensing by a physician, not in the ordinary course of his duties, of drugs and controlled substances in violation of the provisions of this act."	No action taken	Remains in Senate Committee on Public Health and Welfare
H-652 H-653	Pharmacists may substitute from an approved list of equivalents	Oppose	In House Committee on Health and Welfare; Society testified
H-888	Prescriptions in triplicate on check-type paper	Oppose	In House Committee on Health and Welfare; hearings held—Society testified
S-477	Moves amphetamines to Schedule I	Received for information	In Senate Committee on Public Health and Welfare

Bill No.	Explanation	Society's Position	Legislation Position
H-792	Generic prescribing for welfare recipients	Oppose	In House Committee on Health and Welfare; hearings held—Society testified
S-993	Requires additional labeling	No opposition	In Senate Committee on Public Health and Welfare
S-994	Sample Drug Control Act	No opposition	In Senate Committee on Public Health and Welfare
S-995	Pharmacies to post prices	No opposition	In Senate Committee on Public Health and Welfare
S-996	"Prescription Drug Compendium Act"	No opposition	In Senate Committee on Public Health and Welfare
H-2054	Prohibits physicians' prescribing to known drug-dependent persons	Support	Society-offered amendments added; passed House
	Fluoridation		
H-10	Requires companies serving 20,000 or more customers to fluoridate their water	Support	Voted down in the House
	Health Care Costs		
H-2018	"Health Care Facility Cost Containment Act"	Oppose	Society testified; passed House
	Hearing Aids		
S-792	License hearing aid dealers—Academy of Ophthalmology and Otolaryngology favors their own legislation	Opposition	Remains in Appropriations Committee
H-1095	Hearing aids by prescription only	Opposition	Remains in House Committee on Consumer Protection
H-847	Requires warning on hearing aids	No opposition	Remains in House Committee on Consumer Protection
H-1827	Regulates sales and salesmen of hearing aids	Support with Academy of O and O amendments	Hearings held on March 26; Academy of O and O testified
	Home Health Agencies		
H-1942	"Home Health Agency Act"	Under consideration	In House Health and Welfare Committee
	Hospitals		
S-631	Approval by State of hospital construction	No opposition	Referred to Senate Committee on Public Health and Welfare
H-987 S-863	Governor's Comprehensive Health Care Proposal	Oppose, but can support certain features	In House and Senate Health and Welfare Committees

Bill No.	Explanation	Society's Position	Legislative Position
S-1326 H-1710	Requires Certificate of Need, licensure of hospitals, etc.	Oppose Certificate of Need portion	House passed H-1710
	HMO		
S-1225 S-1226 H-1919	Regulates both non-profit and proprietary HMOs	No opposition if Foundation not affected	H-1919 passed House
	Hypnotism		
H-1040	Regulates the practice of hypnotism	Support	Recommitted to House Committee on Professional Licensure
	Identification		
H-785	Identification cards to coronary patients	Support in principle	Referred to Committee on Health and Welfare
	Immunization		
H-1362	Requires school physicians to immunize children of indigent parents	Support	Recommitted to House Committee on Appropriations
H-1363	"Advisory Health Board" to make rules concerning immunization prior to school entry	Support	Passed House and Senate—Act 66
H-1364	Amends "Public School Code" to require schools to abide by the rules of the Advisory Health Board	Support	Passed House and Senate—Act 67
H-1365	Exempts physicians and nurses from liability when participating in mass immunization programs	Support	Passed House and Senate; Conference Committee Report before Senate
	Licensure		
S-36	Adds four consumers to all professional and occupational licensing boards	Oppose	Remains in Committee on State Government
H-803	Places two consumers on professional licensing boards	Oppose	Remains in Committee on State Government
S-1814	Turns certain licensing boards' authority over to Commissioner	Under study by legal counsel	On Senate calendar
	Medical Education and Licensure		
H-759 H-760	Society-sponsored amendments to the "Medical Practice Act"	Support	Passed House and Senate: Acts 189 and 190
H-1074	Requires six months internship in General Practice	Oppose	In House Committee on Professional Licensure
S-1023	Repayment to state by medical students	Oppose	Referred to Appropriations Committee
	Medical Examiner		
H-451 H-883	Medical Examiners permitted in second class counties	Support H-451	Referred to Committee on Urban Affairs

Bill No.	Explanation	Society's Position	Legislative Position
	Mental Health		
S-170	Defines "grave mental disability"	New version being opposed, in part, by the Pa. Psychiatric Society	On Senate Calendar
S-56	Creates legislative committee on mental retardation	New version being opposed, in part, by the Pa. Psychiatric Society	In Senate Committee on Rules
H-143	Involuntary admission procedures	Studied by Pa. Psychiatric Society—Needs better drafting	In House Committee on Health and Welfare
S-730	"Rights of Mental Patients Act"	Support in principle	Referred to Committee on Public Health and Welfare; hearings held
S-731	Elimination of peonage in state hospitals	Support in principle	Hearings held; Society testified
H-868	Removing requirement that directors of state facilities be physicians; referred to Pa. Psychiatric Society	Oppose	Passed House; in Senate Committee on Public Health and Welfare
S-1239	"Mental Health Procedures Act"	Pa. Psychiatric Society and PMS suggested amendments	Recommitted to Committee on Public Health and Welfare; hearings held
	Nursing		
H-129 H-130	These bills amend the professional nursing law to expand the definition of nursing, etc.	Support	H-129 passed both Houses—approved by the Governor
	Opticians		
S-854	"Dispensing Optician Law"—State Board of Optometric Examiners to license opticians	Oppose	In Senate Committee on Public Health and Welfare
H-2424	State Medical Board to regulate Opticians	Support	In House Appropriations Committee
	Optometry		
S-570	Optometrists with additional training to use topical drugs	Oppose	Passed Senate and House; Act No. 29 of 1974
	Paramedical Personnel		
H-355	Waiver to service-trained corpsmen	Oppose	Remains in Committee on Professional Licensure
S-627 S-629	Permit Medical Board and Osteopathic Board to license physicians' assistants	Oppose; favor language in H-1468 and H-1469	Both bills remain in Committee on Public Health and Welfare

Bill No.	Explanation	Society's Position	Legislative Position
H-889	Medical Board to License Physicians' Assistants' practice	Oppose; favor language in H-1468 and H-1469	Remains in Committee on Health and Welfare
H-1468 H-1469	Certification by Medical and Osteopathic Boards	Support with appropriate amendments	Passed House
	Peer Review Protection		
H-1729	Protects members of review committees and their records	Support	Passed; Act 193
	Physician Shortage Areas		
H-1316 H-1363	Dr. Speller's recommended state and community-supported medical facilities in medically-deprived areas	Oppose	Recommitted to Appropriations Committee
H-1549 H-1550	Pennsylvania Medical District Act Pennsylvania Medical Education Planning Act	Oppose H-1549; Support H-1550 in principle	Both bills in House Education Committee
	Physical Therapy		
H-2467 H-2468	Separate Board to License physical therapists	Oppose	In House Professional Licensure Committee
	Public Welfare		
H-609	Establish ceilings on Welfare payments	No position	In House Committee on Appropriations
	Rubella Testing		
S-1655 S-1656 H-2115	All these measures require premarital testing for rubella	Oppose in present form because they require unusual physician judgment	All in Committee
	TV Tubes		
H-2595	Prohibits persons from discarding TV picture tubes until neutralized	Support	In House Committee on Law and Justice

Appendix M

Supplemental Report
Council on Public Service
(Referred to Reference Committee on Public Service)

The priority project of the council over the past year has been, of course, membership recruitment in the Pennsylvania Medical Cooperative. Six months, April 1 through September 30, were allocated for an extensive recruitment drive. At the conclusion of the drive the council met to evaluate the status of the Cooperative and make a determination on what future course, if any, the council would recommend to the House of Delegates.

The council would like to report that it is both gratified and disappointed with its effort to recruit members into the Cooperative. It is gratified because the six-month recruitment effort has resulted in attracting a physician market in excess of the 2,000 recommended in the feasibility study submitted to the House of Delegates last fall. It is disappointed, however, because it was unable to raise the needed $200,000 capital to make the Cooperative operational. The reason for the latter is quite simple. Approximately 40 percent of the charter members belong to group practices. Although this did indeed help us in establishing an adequate market, it made us short of our capital goal.

The result of our recruitment effort as of the writing of this report is as follows: 1,124 physicians have sent in $100 membership fees and an additional 85 physicians have asked to be billed for their fee. Total membership: 1,209 paid or billed, with a market potential in excess of 2,100.

The recruitment drive did prove that there is considerable interest for a mass purchasing organization and the council feels that this unique member benefit should not fail for want of adequate capitalization.

In addition to reviewing the membership figures, the council also reviewed projections on the time involved in developing the Cooperative plus the possible effects inflation has had on the projected $200,000 needed to open the doors for business. In the case of the operational phase of the Cooperative, it is estimated that approximately six months will be required before the Co-op will be able to offer products to physician members. This is probably the maximum amount of time in which we can effectively hold physician interest in the program. In other words, they will want to see some results on their $100 investment.

On the matter of inflation, it is estimated that the initial $200,000 requested has now shrunk by roughly 12 percent. This inflationary rate will have an effect on the initial inventory order, but should not drastically affect the ultimate savings which the Co-op promises. The council believes that there is enough built-in flexibility in the original proposal to be able to cover inflationary increases. However, it felt compelled to inform the House that this matter has been considered.

Since the Cooperative has attracted more than 2,000 physicians to create the needed market, but is short of the capital goal by slightly more than $79,000, the council unanimously is of the opinion that the project should not be abandoned. It has reviewed several options in this regard and recommends that the State Society invest in the Cooperative equal to the resources that would be needed to reach the $200,000 goal. This would enable the council to immediately proceed with the operational stages of the Cooperative. Any delay, in the council's opinion, could be costly in terms of lost membership. In addition, the council recommends that the charter membership recruitment period be extended through January 31, 1975.

In making the recommendations, it should be pointed out that any additional funds presented to the Co-op by the State Society would be handled like the initial $25,000 invested in the membership recruitment effort in that it would be in the form of a loan. This loan would carry a risk to the Society. However, council notes that the Society in 1974 agreed to support the Pennsylvania Medical Care Foundation to a maximum of $100,000 or until it was federally funded; $28,000 of that amount was used by the Foundation in the early part of the year. The council is not questioning the value of the Foundation, but its services cannot be considered tangible membership benefits. The Co-op not only has that potential, but also the potential for encouraging nonmembers of PMS to become active in order to reap the anticipated benefits. Although this doesn't minimize the risk to the Society if it should invest, there is at least that potential for recouping the investment.

The continuation of the charter membership recruitment phase through January 31, 1975, does carry a price tag which should be considered. Additional mailings to members of PMS plus travel expenses to present the program around the state for this period of time would cost the Society approximately $5,500. However, it should be pointed out that approximately $1,500 remains from the original $25,000 budgeted for the six-month recruitment drive. Therefore, an additional allocation of $4,000 would be required.

With this extension, it is conservatively estimated that we should increase the paid membership to no less than 1,500 or $150,000 in capital. This would still require a State Medical Society investment of approximately $50,000 if the Cooperative is to start with the projected $200,000.

Although the State Society is being requested to commit at this time up to $79,000 so that the operational phase may begin, it is doubtful whether that total amount will be needed. In addition, any funds that are required will not be used until the Cooperative is prepared to order its initial inventory. Ordering of inventory will probably not occur until the last month or so of the planned six-month implementation phase. In the early developmental stages, costs will be minimal in relation to the outlay of capital for inventory.

The council's formal recommendation is as follows:

The Council on Public Service, in recognition of the adequate number of members who have to date expressed interest in the Cooperative, either in individual $100 membership fees or through group participation, recommends: (1) That membership recruitment phase be extended until January 31, 1975 (approximate cost $4,000); (2) That the Pennsylvania Medical Society consider favorably the investment of funds to reach the projected starting capital of $200,000 for the Co-op (maximum of $79,000) and (3) That the Council be authorized to begin as early as possible all necessary and appropriate arrangements to make the Cooperative operational within the six-month projected time frame.

Appendix N

Supplemental Report Committee on Relationships with Allied Professions (Referred to Reference Committee on Education and Science)

In our annual report, which appears in the 1974 *Official Reports Book* we reported to you that we expected to see, prior to the convening of the House of Delegates, final reports from the "Pennsylvania Commission for the Study of Nursing and Nursing Education" which we further suggested would probably be at some variance with the position taken by the House of Delegates in 1973. As it turned out, we were correct in this forecast, and so your committee held a special meeting on September 4 to consider the several reports

and to suggest recommendations concerning them to the 1974 House.

The report of the commission is in two parts—the first is the report on "Joint Practice", and the second, and more voluminous, is the "Report on Nursing Education." All totalled, there are over a hundred pages, and so it is quite impossible for us to send this to the House in its entirety. Instead, we will present the "recommendations" first, of the report on "Joint Practice", followed by our impressions and recommendations. Second, we will report the recommendations and goals of the report on "Nursing Education" followed by our observations and recommendations.

Recommendations of the Joint Practice Commission

(1) Continuing education programs be instituted under the auspices of colleges, universities, employing agencies, and professional organizations. These programs should be aimed at increasing the nurse's clinical competence and communication skills, as well as updating the information obtained in basic programs. Local, regional, and state-wide planning should be done in order to provide the number and kinds of continuing education programs which are needed.

(2) A network of committees at the state and local levels made up of physicians and nurses be appointed for the specific purpose of identifying and promoting acceptance of the emerging roles of each, recognizing that these roles may vary from setting to setting and area to area.

(3) That differences in health needs of people in rural areas, inner cities, etc., be determined and appropriate action which recognizes these differences be supported by organized medicine and organized nursing in Pennsylvania.

(4) Incentives be sought to encourage redistribution of services of physicians and nurses in Pennsylvania.

(5) Educational programs for the public be formulated and implemented in order to stimulate an informed demand for health care on the part of citizens to be served.

(6) Incentives be developed to promote the retention of nurses in the practice field.

(7) Current practice patterns which focus primarily on acute care be altered to include and emphasize preventive care, rehabilitative and longterm care.

(8) Legislation be proposed in Pennsylvania which would recognize the need to provide for flexibility in the roles to be accepted by nursing and medicine.

(9) State Board of Examiners, both medicine and nursing, in collaboration with their respective associations, establish educational requirements and reasonable standards of care which will serve the citizens as well as protect the practitioners.

(10) That the practice of nurses and physicians be altered so that nurses can assume greater responsibility for delivery of primary health care services in identified settings.

(11) Nursing and Medicine take appropriate action to insure that practice roles reflect consumer needs.

(12) Every possible means be encouraged to promote change in the way physicians and nurses relate to each other to the end that both are working for the patient in congruent roles agreed upon by both professions.

(13) A method of reimbursement be instituted so that the practitioner who performs an essential health care service for a patient may validate that service and be compensated for it.

(14) Nurses accept responsibility for their professional actions and accountability for decisions made in relation to professional practice.

(15) Local committees of physicians and nurses work cooperatively to resolve regional health care issues.

(16) Health care professionals in Pennsylvania make a concerted effort to gain increased knowledge and understanding of the political organizations and the legislative process in order to become effective in influencing the legislation which affects the health care in the Commonwealth.

(17) In view of the foregoing, the commission recommends that a joint committee be formed by the Pennsylvania Nurses Association and the Pennsylvania Medical Society to assist these groups to work cooperatively in providing leadership to physicians and nurses in working together toward resolving health care issues in Pennsylvania.

The committee went over in detail the document entitled "Final Report of the Joint Practice Commission." Our feeling, generally, is that the document is wordy and confusing. It appears to be an opening ploy of a movement to eventually obtain co-equal rights, privileges, and responsibilities with physicians in the delivery of health care and the practice of medicine. This is illogical. While nursing and medicine correlate, that correlation is based on cooperation, mutual respect, and striven output within each profession's training and capabilities toward the optimum care of the patient. The care of the patient is the only reason for the existence of either profession.

In this context, the committee feels that there is a definite place for expanded function of nurses as members of the medical care team. The number of nurse specialties is growing, all contributing logically to health care as members of the team. This trend is to be encouraged as long as it contributes to, rather than confuses, the patient-care effort. The qualified nurse specialist is capable of contributing invaluable input in cooperation with physician leadership. She is capable of creating doubt and confusion between professions when she goes counter to that concept.

The qualified nurse has long been the logical assistant to the physician in patient care. As the practice of medicine expanded and became more and more complex and demanding, the nurse function should have grown apace. While it did do so to an appreciable degree, there also developed a counter trend of pulling away from the team effort. The final report of the "Joint Practice Commission" catalogues that diversion in its seventeen recommendations. That counter trend has also been, in

part, responsible for the remarkable growth and acceptance of the physician's assistant, an apt illustration of the law of nature that when a vacuum is created, some force or substance moves in to occupy the space.

In view of these opinions and the divergence between the official 1973 Pennsylvania Medical Society policy and the Joint Practice report, it is our recommendation that the Society withhold support of the report of the Joint Practice Commission until such time as appropriate representatives of Pennsylvania nursing and the Pennsylvania Medical Society can discuss it. The House should, instead, reiterate its support of the 1973 position on nursing.

Recommendations and Goals of the Pennsylvania Commission on Nursing Education

Summary of Recommendations

The Pennsylvania Commission on Nursing Education recognized their responsibility to the nursing needs of consumers and potential nursing students in developing and organizing educational systems which will prepare qualified practitioners of nursing. In order to provide more adequate health care to the citizens of Pennsylvania, the basic structure of nursing education must change. The commission believed that this can be accomplished by concerted action, experimentation, and change augmented by joint federal, state and local funding, state leadership and local participation.

The Pennsylvania Commission on Nursing Education recommends:

(1) That nursing education be positioned in the general system of education in the Commonwealth of Pennsylvania. Educators must proceed to bring about this change through planned transition.

(2) That all educational programs be designed to allow for articulation into other levels with each level maintaining its own integrity.

(3) That small programs within Pennsylvania be terminated or consolidated into larger programs to reduce the per unit costs of education and provide for improved utilization of faculty.

(4) That joint planning take place among academic institutions, hospitals, and other health care facilities in an effort to improve resources and utilization of clinical teaching facilities and faculty.

(5) That the State and Regional Comprehensive Health Planning Agency of the Pennsylvania Department of Health and the Bureau of Planning of the Pennsylvania Department of Education explore the possibilities of sharing increasingly scarce faculty resources.

(6) That institutions for nursing education develop new approaches for assessing the quality of prior nursing experience and practice for the purpose of credit and advanced placement of students.

(7) That nursing preparatory institutions develop improved admissions procedures to decrease student withdrawals and academic failures.

(8) That resources and funding for graduate education in nursing be expanded to meet specific needs within each region of the state.

(9) That continuing education for nurses be extended and expanded to allow for increased learning opportunities through organized and planned programs.

(10) That a state center for continuing education for nurses be developed to serve as a means for effective regional coverage and dissemination of information relating to continuing education.

(11) That legislation be passed to update the Professional Practice Acts to facilitate the development of new and improved practice.

Goals

I. Ensure the Restructuring of Nursing Education within the General System of Education in Pennsylvania

Recommendations:

(1) Those hospital schools that are strong and vital, endowed with a qualified faculty, suitable educational facilities, and motivated for excellence be encouraged to seek and obtain regional accreditation and degree-granting power.

II. Support Collaboration between Nursing and General Education in Developing and Implementing Dynamic and Innovative Educational Programs and Policies

Recommendations:

(1) The institutions for nursing develop new approaches to the matter of admissions including: (a) Development of both written and performance examinations to assess the quality of prior nursing experiences and practice for the purposes of credit and advanced placement. (b) Development of achievement, placement, and diagnostic examinations in academic subjects to provide credit and proper placement of individuals within instructional programs.

(2) To decrease student withdrawal and academic failures in nursing preparatory institutions: (a) Study their application procedures, academic advising, and student completion data for the purpose of developing better selection and counseling. (b) Investigate the development of more individualized programs of instruction that require accomplishment of curricular objectives, but permit variance in student rate of learning and in number of courses taken at any one time.

III. Ensure the Availability of Graduate Education in Nursing for the Potential Student Population Throughout the Commonwealth

Recommendation:

(1) The state master planning committee for nursing education be particularly concerned that the number of graduate programs in nursing be consistent with the human and economic resources, and that the inauguration or expansion of weak programs not be permitted.

IV. Extend and Expand Learning Opportunities for Nurses Through Organized and Planned Continuing Education Programs

Recommendation:

(1) The state master planning committee for nursing identify one or more institutions to be responsible for

regional coverage of continuing education programs for nurses within the area, and, further, that: (a) Federal and state funds be utilized to plan and implement continuing education programs for nursing on either a statewide or broader basis (as suggested by the current interstate compacts for higher education); and (b) In the face of changing health roles and functions and the interdependence of the health professions, vigorous efforts be made to have continuing education programs jointly planned and conducted by interdisciplinary teams.

Your committee, at its meeting, felt that the outstanding point noted in reviewing this rather extensive document is that no mention is made of patient care as the primary motivation for nursing and nurse education. The entire document seems to be nurse rather than patient-oriented. On the other hand, the Pennsylvania Medical Society's position paper on nursing has as its opening statement, "The best possible health care of our fellow human beings is the reason for the existence of, and should be the primary goal of, the professions and technologies concerned with all facets of health."

The committee also noted that the Society's position on nursing contains many of the points made in the report of the Commission on Nursing Education. Likewise, the AMA position on nursing, published in 1970, emphasizes many, if not most, of the points in the commission report.

Throughout the document, the licensed practical nurses are directed in many places to cooperate with the Pennsylvania Nurses Association and the Pennsylvania League for Nursing in obtaining and promoting the goals and sub-goals of the report. In spite of this, licensed practical nurse schools are mentioned only briefly—particularly, it is noted that the licensed practical nurses should cooperate with the other organizations in promoting the establishment of appropriate graduate education. Licensed practical nurses, unless they have appropriate degrees, are not eligible for graduate work.

Mention is not made of educational provisions for the various types of nurse specialties, who are, by their nature, physician-nurse collaborative enterprises, i.e., nurse anesthetists, midwives, operating room nurses, orthopaedic nurses, stomal technicians, pediatric nurses, emergency room nurses, intensive care nurses, etc. Neither is continuing education for nurse specialists mentioned, although it might be considered to be blanketed under Goal IV.

Of the four goals listed in the report, we feel the Pennsylvania Medical Society can agree in principle with minor reservations in Goals III and IV, promotion of graduate education for nurses and promotion of continuing education programs for nurses.

A lesser degree of concurrence can be given to Goal II in the implementation of dynamic and innovative educational programs.

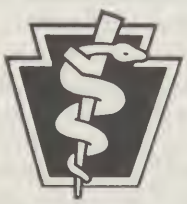
Under Goal I, restructure of nurse education within the general education system of Pennsylvania gives practically no ground for support. The Pennsylvania Medical Society paper does not concur in the closing of diploma schools which this goal will require nor the effect it would have on the licensed practical nurse training system of the state. The alternate suggestion that diploma schools obtain degree-granting powers is impractical.

The Pennsylvania Medical Society can support the degree ladder challenge examinations and equivalency determinations which facilitate and speed up nurse advancement in the educational field.

Under Goal I, the comprehensive health planning function of the State Health Department is encouraged to collaborate in the identification and initiation of planning activities between academic institutions and health care institutions; also to assist in the closing of small nursing education programs and the exploration of the possibilities of sharing in increasingly scarce faculty resource. Your committee cannot concur in these latter provisions of Goal I.

Accordingly, your committee recommends that Goal III be supported in principle; Goal II be supported with the above-mentioned changes; and Goal I be disapproved.

QUESTIONS? SUGGESTIONS!
are invited for consideration by
The Committee on Objectives
Pennsylvania Medical Society



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